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Sexual Discord in Marriage

A FIELD FOR BRIEF PSYCHOTHERAPY

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Foreword by Michael Balint

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Foreword

Marital discord is perhaps the most important source of human unhappiness. It is no wonder, then, that all sorts of attempts have been made to help the couple in their distress. It is surprising to discover how little the medical profession has been involved in any of them. Even today one finds hardly any reference to marital unhappiness in the leading medical journals, and neither pathology nor therapy of marital disharmony is taught at any of the teaching hospitals at the present time.

Other professions have behaved differently. For instance, the legal profession has always, and in practically every country, been deeply concerned with marital troubles. The common law, as well as every form of civil code, contains a valuable section that tries to bring some order into the morass caused by marital discord by defining the rights and duties of each of the two partners, and their obligations towards their children; and by devising some permissible ways of separating the partners whose marriage has completely broken down. Still earlier than the legal profession, and in modern times parallel to but independently from it, the various churches have evolved methods for dealing with marital unhappiness, and the priest in practically every religion receives some sort of training in how to understand unhappy marriages and how to relieve the distress caused by them. Certain religions allow some freedom to the two partners to separate if they feel that nothing can be done to improve their marriage, others lay down very strict conditions for any separation, but all of them have established a body of precepts and practices with regard to this problem under the name of pastoral psychology. The police have always been called in when the disharmony degenerated into physical violence, and of course have had some training in how to deal with such situations. A more modern innovation is the movement called Marriage Guidance. Its voluntary workers have devised techniques

for helping people with marital difficulties and it is insisted that all such workers should be instructed in these techniques. The social workers and the psychologists represent, perhaps, the two newest professions to be involved. Both disciplines offer very elaborate training to equip workers with the requisite skills.

A further interesting point is that all these professions are brought in to deal only with certain limited aspects of the marriage, and the decision as to which of them should be asked for help depends not so much on the nature of the marital breakdown as on its most disturbing symptom. I have already mentioned that the police are appealed to when there has been some physical violence; symptoms that necessitate the services of a lawyer are financial conflicts, or quarrels about the children, etc.

Of all the representatives of the various professions, the minister and the doctor tend to be the first to be turned to for assistance. As I have said, the minister has had some training in the handling of marital problems. There is, however, hardly any preparation for work in this sphere during the training of the family doctor, and yet it is undeniable that he is among the first to be consulted in case of need. Quite often the approach to the doctor is not direct; after all, to consult a doctor you must have an illness, that is, you must accept the role of a patient who comes with a proper complaint; so what the doctor hears first are all sorts of symptoms or complaints which, however, only thinly disguise the deep unhappiness.

Because of his lack of relevant training, the doctor has some difficulty in finding the right answers. Although he knows full well that the root of the symptoms is in marital disharmony, often what he does is to treat the symptom and not the real illness; thus he gives an antidepressant if his patient is depressed because his marriage has 'gone bust', a tranquillizer if his patient is worried, a stimulant if his patient finds the burden that he or she has to carry too much, and so on. This technical attitude is the consequence of present-day medical thinking, which is first and foremost biological, and therefore centred on the one person. This approach means that every complaint must be understood to be the result of something that has been changed in the one particular person who comes with the

other partner, but *between the two*. Current medical thinking, based chiefly on the study of the one isolated individual, cannot say much about problems of this kind. Furthermore, the trouble between the two people, much more often than not, is centred in their sexual incompatibility. Here again modern medicine is ill at ease because sexual incompatibility emanates not from the one or the other partner, but from both, that is, from their relationship to each other.

Because of its present limitations, medicine has not developed adequate methods for studying the pathology and therapy of human relationships, surrendering these areas to other professions such as psychology, sociology, and education. These other disciplines have gladly accepted this field but, not being medically trained, they have tended to put the chief emphasis on the psychological processes and connections, neglecting almost entirely the body. In many ways psychiatry, the branch of medicine that has paid some attention to marital difficulties, has drifted in the same direction.

Dr Courtenay's book is one of the attempts being made to remedy this unsatisfactory situation. He reports the research project undertaken by a team of doctors who were working in the Family Planning Association's marital problem clinics. This setting helped considerably to keep the research work properly balanced. On the one hand, the family planning clinics are centred firmly on the genital-sexual functions, that is, on the body; on the other hand, the symptom of unhappiness compels the doctors to take psychological factors most seriously. The present volume demonstrates this double approach, which may be called truly psychosomatic, in its practical application. It contains hardly any theory. Rather, it is concerned to show what therapeutic problems were encountered, and what the members of the team tried to do to solve them. We shall need many such studies before a reliable theory of marital interaction can be worked out – a theory based not on wish-fulfilling speculation but on firm clinical observations.

I wish to end my preface by recommending that the general plan of this research should be adopted by future ventures. The essential feature of the procedure was that every doctor was asked at the inception of the treatment to predict in verifiable terms what results he expected from his efforts. These predictions were taken down in writing at the time. Thus in the follow-up period it was not too difficult to verify, or to refute the validity of, these predictions. On this

basis it was possible not only to appraise the accuracy of the predictions and the doctor's therapeutic skill, but also to assess the degree to which the doctor, and the whole research team, were able to understand the problems presented by the patients and to discern the therapeutic measures that were needed in every case.

Michael Balint

Author's Preface

Presenting the ideas and work of one's colleagues inevitably entails greater responsibility than does presenting one's own work. The research described in this book was carried out by one of two groups of a seminar, led by Dr Michael Balint, with the assistance of Mrs Enid Balint, Dr J. L. Wilson, and Mr Peter Hildebrand, and composed of fourteen doctors connected with the Family Planning Association. I was one of these fourteen, and was appointed as record officer to my group. When the research project was completed I was asked by Dr Balint and my fellow group members to prepare an account of it for publication.

Transcripts were available of all the meetings of both groups, as also were many versions of a method of recording interviews, devised originally by Dr Balint, developed by the Focal Therapy Workshop, and adapted by Dr T. F. Main for use at the Cassel Hospital.

A draft report of each case was sent, for comment and clarification, to the doctor who had undertaken the treatment, and any disputed point on which agreement could not be reached between myself and the treating doctor has been left out of the final approved report.

The psychotherapy of psychosexual problems often involves material that appears rather crude in print, but a study on this subject, if it is to be of value to others working in the same field, must portray honestly even somewhat distasteful situations. On the other hand, in the selection of illustrative data, the patients' right of privacy must be the first consideration. Synonyms have been employed throughout, and for this purpose the names of London telephone exchanges have been used. In addition, external details concerning the patients that might have led to their recognition have been omitted or altered. The formal method of reporting cases has been a help in this respect, but there is always the possibility that a patient may recognize himself or herself because care has had to be taken, at the same time, not to

distort the essence of the situations encountered. It is hoped that it will be clear to any patient who should find himself in this position that no one else would be able to identify him.

I thought that I had been a diligent follower of all that went on during the two years the seminar was in being, and it was a constant surprise to perceive, on careful re-reading of the transcripts of the cases, how many fresh nuances and insights could be appreciated. More especially, there was a steadily growing realization, and admiration, of Dr Balint's capacity to see ahead, as regards both the possibilities and the dangers of the research project. It was only in slowly sifting the mass of material that I came to understand the work in the round, in a way that I was quite unable to do when I was actually involved in it week by week.

Without Dr Balint's support and advice this volume would never have seen the light of day; nevertheless, the final responsibility for it must be mine.

CHAPTER 1

Introduction

It seems that the treatment of psychosexual difficulties has become the cinderella of the psychiatric and social services.

Despite the great expansion of these services during the last fifty years, generated by immense advances in the understanding and treatment of mental illness, psychiatrists are confronted by so many pressing demands that they can give their attention to only a tithe of the cases involving marital difficulties, and must of necessity concentrate on those that are most severe.

Furthermore, general practitioners, even if they have acquired in the course of their postgraduate training the skill to deal with emotional disturbance, may feel that there are more urgent problems to tackle in their daily work than neurosis associated with the marital relationship.

The hiatus of provision in this area has been so glaring that various social agencies, outside the National Health Service, have had to step into the breach, among them the Family Discussion Bureau (FDB) and the National Marriage Guidance Council.

In recent years the Family Planning Association (FPA) has set up special clinics to deal with marital difficulties, not through deliberate policy emanating from the centre, but because the pressing need for such a service had become obvious to doctors working in FPA birth-control clinics, to which patients brought a multitude of problems arising out of the sexual relationship in marriage.

In 1958 the FPA initiated a training-cum-research scheme for doctors engaged in these clinics, under the leadership of Dr Michael Balint. Initially, ten women doctors participated in a seminar with him for three years, studying various problems, and a report of one aspect of their research work (that of unconsummated marriages) was published in 1962 under the title of *Virgin wives*, by Dr L. J. Friedman. The technique used was an extension of those developed by Balint in

his work with general practitioners, and described in his book *The doctor, his patient and the illness* (1957a).

Balint had recognized that, though long-term psychotherapy, particularly psycho-analysis, might achieve good results in the treatment of a small number of highly selected individuals, it could not be applied to more than a negligible percentage of those who were suffering from neurotic misery. He then began to investigate how the experience of a lifetime of psycho-analysis might contribute to less far-reaching therapeutic aims over a much wider field of operation. In the application of this idea to psychotherapy in general practice, he described how the training depended on the doctor's gaining insight into his own personality. By achieving a definite, though limited, change in his personality, the doctor was enabled to deal with his patients on a different level, in that his response to them became conscious and professional, rather than remaining unconscious and personal.

that described by the caseworkers of the FDB in the book *Social casework in marital problems* (1955) by Kathleen Bannister and others. The FDB caseworkers always invited the absent spouse to come to the Bureau, though the question of when and how was always discussed with the client who presented first; it was made clear that a colleague would see the other partner, and it was deemed absolutely necessary to bring out the second partner's feeling about coming to the Bureau. Only 7 per cent of the first contacts included both partners. The caseworker who first saw the client always carried on the treatment, since it was realized that the initial interview was of cardinal importance in that it must create the climate in which the relationship between client and worker could grow. In general, the proportion of 'two-partner' cases tended to be greater in those cases showing a high rating of 'casework' gains, so the prognosis seemed considerably more favourable if both husband and wife took part. On the other hand, cases of unconsummated marriage always proved very resistant.

The caseworker methods that were the central theme of the FDB book are to be seen in relation to the special setting in which the work was done. The conception of the group of workers as a team, and the integration of psycho-analytic consultants into the unit, were its essential features. The joint task was to develop a skill for helping clients to deal with their inner conflicts, and the method enabled workers to absorb their growing experience emotionally as well as intellectually, and then to apply it in practice. This was done by means of case conferences initiated by Michael and Enid Balint at a weekly group meeting, which in turn led to the formation of the general practitioner seminars at the Tavistock Clinic, and finally to the FPA seminar.

Returning to the question of the setting of the FPA special clinics, it was seen that the technique evolved in the treatment of unconsummated marriages was not necessarily appropriate to other problems, just as the FDB technique had not yielded good results in the case of non-consummation. The setting was clearly not directly analogous to general practice either. It is well recognized that the general practitioner deals with illness which it lies within his competence to diagnose and treat, and refers other cases to the appropriate consultant or specialist services. Nevertheless, it is also recognized that he may become a clinical assistant in a hospital setting and be trained by a specialist to a higher degree of competence in a particular subject;

subsequently, by handling under supervision the more straightforward cases in this area, he enables the consultant to devote more time to the more difficult problems.

The original FPA seminar was therefore enlarged by the addition of four male doctors, and then split into two groups meeting on different days of the week, with the new research-cum-training aim of developing a technique suitable for dealing with patients suffering from marital disharmony and sexual difficulties.

It is now time to introduce the doctors, as they were at the beginning of the fourth year of the seminar.

Dr Michael Balint, psychiatrist and psycho-analyst of thirty-five years' experience, a prolific contributor of papers to psycho-analytic journals, over and above his work in developing new approaches to the training of doctors in psychotherapy, led both groups throughout the project.

Mrs Enid Balint, a very experienced psycho-analyst, who had assisted her husband in all his training projects, spent some time with each group.

Dr J. L. Wilson, psycho-analyst and consultant at the Tavistock Clinic, assisted Dr Balint in one of the groups for a year.

Mr Peter Hildebrand, psycho-analyst and clinical psychologist, assisted Dr Balint in the other group throughout the whole project.

Dr Rosamund Bischoff, with twenty-five years' experience of general practice and a particular interest in obstetrics and 'medical gynaecology', had worked for the FPA, including special clinic work, for many years. She was a foundation member of the seminar.

Dr Margaret Blair, a general practitioner with a particular interest in 'medical gynaecology', had also worked in an FPA special clinic. She was a foundation member of the seminar.

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Dr Alison Giles was in general practice for eight years, followed by twelve years' work in the FPA, including special clinic work. She had been a member of the seminar for three years, but left it after a little more than a year of the present project.

Dr Ruth Lloyd-Thomas, a general practitioner with a major interest in 'medical gynaecology', had ten years' experience of work in the FPA. She had been a member of the seminar for three years, but left after six months' work in the new project.

Dr Eileen Mallinson, a maternity and child-welfare medical officer, had been interested in 'medical gynaecology' for fifteen years, and was a foundation member of the seminar.

Dr Eleanor Mears, in the course of five years of general practice, became interested in 'medical gynaecology', which thereafter became her exclusive interest when she became medical secretary of the FPA. She was a foundation member of the seminar.

Dr H. S. Pasmore, a general practitioner of twenty-five years' experience, had been a member of a seminar for general practitioners at the Tavistock Clinic for seven years, and had been a member of the FPA seminar for some months.

Dr Jean Pasmore had been especially interested in 'medical gynaecology' in general practice, and had done many years' work with the FPA, including special sessions She was also a medical officer at the Marital Difficulties Clinic at the Cassel Hospital. She was a foundation member of the seminar.

Dr Mary Pollock was a fully qualified gynaecologist working at the Royal Free Hospital, London, and was particularly interested in the work of the FPA, of which she had twenty years' experience. She was a foundation member of the seminar.

Dr Jeffrey Shaw was a psychiatric registrar at a London teaching hospital.

Dr Rosalie Taylor had had twenty-five years' experience of 'medical gynaecology', combined with general practice for ten years. She was a foundation member of the seminar.

Dr Blend and Dr J. Pasmore attended both groups for part of the time.

At the start, both newly formed groups of the enlarged seminar continued to use the method of working which had been employed

during the first three years. The leader asked who wished to present a case, and an impromptu agenda was drawn up. A verbal report of each case was then given, without recourse to case-notes, and general discussion followed, all of which was recorded verbatim by the seminar secretary, Mrs Martin.

The members of the original seminar had previously learnt to become aware of their own automatic patterns of response to patients, and had gradually acquired some degree of freedom from these patterns. This had been achieved in a free and friendly atmosphere in which each doctor could face the experience that one's behaviour is often entirely different from what one intended, and from what one has always believed it to be. This realization is not easy to bear, but with good cohesion in the group the limitations of each doctor could be brought out into the open and accepted, at least partially, by the doctor concerned. He or she had to observe and report his observations to the seminar. Axiomatically, these had to be conscientious and sincere, but, beyond that, every report was subjected to constructive criticism, which in turn led to the doctor's recognition that his ineptitudes were expressions of his character and personality. After listening to the criticism, the doctors had, in the subsequent therapeutic work, to test out where the balance of truth lay between the group's views and their own. Thus the doctors' acquisition of therapeutic skill had been inescapably accompanied by the discovery

The seminar seemed in a confused state. In the first three years everyone had known what he was doing and had done it, but now the doctors were behaving like psychotherapists without proper psychotherapeutic training. If the research aim was to forge a technique suitable for use in the special clinic setting, the aim of training was to discover whether the doctors in the FPA who were staffing these clinics could reach a standard at which they could safely function in a consultative capacity under the direction of a supervising consultant. In general practice there were built-in safeguards for the patient. If the doctor made a mistake the patient could respond by not returning to him or by changing his doctor, whereas in the present setting the result of the doctor's intervention might remain unknown, unless the patient responded to treatment or gave the doctor a snub, the latter being a rare occurrence. If the patient did not return the reason would be obscure, so the problem of how to evaluate the doctor's work also arose. The absent patient might have been helped sufficiently or, alternatively, his chances of getting appropriate treatment might have been seriously compromised.

Accepting every case that presented and hoping for the best was not proper medicine, but this was tending to happen because the doctors were making a diagnosis gradually in the course of treating the patient. Many cases presented with an apparently simple complaint, which on closer inspection disclosed a complex problem. It was clear that the patient should be examined and diagnosed with care, otherwise the doctor might find himself involved in a case which it was beyond his skill to treat. It was the task of the doctor to treat impotence and frigidity, and, since these were symptoms of an ill personality, it was necessary to approach the patient in a way that would enable the immediate difficulty to be solved without allowing treatment to be complicated by the further problems that might become apparent. The question was how to keep the work within the ambit of the doctors' capabilities. The good results arising from the work with unconsummated marriages might not have been thoroughly understood, and might have left many problems unsolved, but with that kind of case it was possible to decide whether the results stood up to investigation or not, since consummation was a definite end-point in the treatment.

In the present project there were no firm criteria for a successful conclusion, because of the diversity of the problems and the absence

of any sure guide to the appropriate technique. A further difficulty was that patients appeared to be asking for a magical cure, and resented as an intrusion the doctors' efforts to understand what their symptoms meant. To assess whether a doctor's technique was inadequate for the understanding and treatment of a case remained one of the prime concerns of the seminar. The capacities of both patient and doctor had to be appraised. Some patients might appear to be cured very rapidly, and here the analytic concept of a flight into health had to be reckoned with; on the other hand, a slavish adherence to analytic theory might play havoc with the patient. The seminar had indeed started out with a combined physical and psychological approach, but was now engaged in trying to apprehend the patient's character

decided to adopt this procedure in an attempt to acquire diagnostic skill, the alternative being to remain in the general practitioner type of setting which seemed inadequate to the needs of many of the patients attending a special clinic.

Before the new method of working of the seminar is described, there follows an account of the history of Initial Interview Forms, showing their evolution from the earliest type as used by the FDB, through those employed in the FTW, into the final pattern adopted by the FPA seminar.

CHAPTER 2

The Form

Before discussing the detailed nature of 'the Form' as it gradually evolved, it is necessary to understand its purpose. It was quite different in intention from a questionnaire, or from a series of headings designed to enable the doctor to structure the interview in such a way that the mind of the patient would be examined systematically, leaving out nothing of importance yet not allowing the interview to wander off into digressions.

The Form was envisaged as a means of *reporting* an initial interview (or possibly a group of two or three interviews) in which the patient was allowed to talk about what he pleased. After the interview was over the doctor applied the Form as a template to the material which had emerged, so that positive and negative factors related to the patient's illness would stand out clearly.

The standard psychiatric examination is designed to elicit responses from the patient in accordance with a preconceived plan in the doctor's mind, and this is likely to lead to a different type of response from the patient from that which would occur in an unstructured interview. It invokes the orthodox medical approach to a patient, accenting the taking of careful personal and family histories in relation to the presenting complaint, and going into detail over such matters as sexual and marital experience, work record, and an assessment of the personality before the onset of the illness. An independent informant, usually a friend or relative in close contact with the patient in his daily life, is welcomed so that his more objective observations may be balanced against the patient's subjective

gation. The whole pattern is, indeed, a specialized reflection of the customary method of examining a patient clinically.

While this is admirable, it tends to obscure some of the difficulties inherent in such an approach. The history-taking in relation to the assessment of personality must be concerned with a multitude of factors. Social relations constitute a significant field of inquiry, and will have taken into account all interpersonal relationships: those with family, relatives, and social groups; those encountered in the work situation; in organized activities in political, religious, or other spheres; and in the course of leisure-time interests and hobbies. Such information serves, in addition, to throw light on traits of fantasy, degree of need for attention, dominating interests, sociability or reserve, and habit patterns as numerous as there are individuals. Intellectual capacity and performance have to be evaluated in the light of interests and activities, and the amount of energy the patient puts into various activities. Some assessment of the general pattern of mood must also be made in order to judge to what extent the patient's illness has disturbed his usual affect. Finally, the patient's attitude to bodily functions, such as appetite, sleep, bowel action, and health in general, has to be taken into consideration.

It will be seen that the aim is to build up as *comprehensive* a picture of the patient's world as is possible in the limited interview time.

The psychodynamic approach to the patient is initially much more permissive, allowing the patient to tell his story in his own way, using the minimum of questions to stimulate him to produce the material *he* thinks relevant to his complaint. This makes it possible for the doctor to establish a real contact with the patient, but the danger is that, if session followed session in this manner, with the doctor taking up the patient's various offers as they arose, a diagnosis could be made only after a prolonged period, and brief psychotherapy would occur only as a chance phenomenon dictated solely by the severity (or rather the lack of it) of the patient's illness.

The whole idea of the psychodynamic diagnostic interview was to achieve a certain amount of *change* in the patient, and this could even be specified: that is, the patient should be enabled to see his problem in such a way that it allowed him to take a therapeutic decision. If the patient's heart or reflexes were examined he was not thereby changed, but if his homosexuality was examined and shown

to be, say, a defence against sadistic aggressiveness, he ought to change to the extent of being able to ask for or reject help.

It was the need to give the patient freedom to express himself, while allowing the therapist to understand this expression fully, that led, in 1949, to the development by Michael and Enid Balint of a Form for use in the FDB. This Form has subsequently been revised several times to meet the needs of the caseworkers (see Appendix to this chapter).

The case-front (called Form A in the Appendix) recorded certain facts about the couple and their families, and also information about the referring agency. The Form proper (called Form B in the Appendix) was concerned with the patient's appearance and manner of presenting his story; with factual material relevant to the diagnosis; and with what brought the client to the Bureau at that particular time, together with his expectations about the possibilities of help, and his conception of himself and other important people. The second section recorded the course of the client-worker relationship under various headings, including the mutual responses of client and worker, and the main themes offered and developed (especially from the point of view of the correspondence between the interview pattern and the patient's usual behaviour). The third section consisted of a summary of the worker's impression of the real problem and the client's personality. The immediate aim of the worker and the necessary steps for

patient's life, then the pros and cons in respect of focal therapy could be gradually established.

The technique of focal therapy consisted in identifying an area of the patient's internal life, the readjustment of which might be so significant that it would influence his symptomatology considerably for the better. This led, in turn, to a search for the technical steps necessary to achieve such readjustment, and to an estimate of the time required.

Malan concluded from the work of the FTW that the generally held 'conservative' view, according to which brief psychotherapy was appropriate only to patients exhibiting an illness of not too severe a symptomatology and of fairly recent onset, was not invariably valid. On the contrary, there was substantial evidence that other factors were of greater consequence and that quite far-reaching and lasting improvements could be obtained in relatively severe and long-standing illnesses. Strong motivation for therapy, a good contact with the interviewer, and at least some constructive response to interpretations seemed to be very important for a good outcome.

The 'focus' would ideally be formulated in terms of an 'essential' interpretation on which the therapy was to be based. If the focus crystallized out of the early sessions, the therapy could be planned accordingly; in some cases, however, continued work might show another, more important, focus which would then have to be used, though it meant that time would have been wasted in unproductive work. This was because the technique necessarily involved pursuing the chosen focus single-mindedly, guiding the patient by partial interpretations, with selective attention and selective neglect. If the material admitted of more than one interpretation the therapist would always choose that which was consonant with the chosen focus, and refuse to be diverted by material apparently irrelevant to it, however tempting it appeared.

This technique assumed a successful interaction between patient and therapist which, by analogy with an idea expressed by Balint (in *The doctor, his patient and the illness*), was described by Malan in the following terms:

'(*a*) the patient offers material, which
(*b*) enables the therapist to formulate a focus, which
(*c*) the therapist offers to the patient, which
(*d*) the patient in turn accepts and works with.'

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During the first few interviews with each client, the worker's task was to assess the client's capacity for using the casework situation, and the kind of help that he, the worker, could most appropriately offer. This called for careful evaluation, not only of the client's reactions in the interviews, but also of the repercussions within his family during the early phase of his seeking outside help. In particular, the other spouse's willingness to come for interviews and his capacity to use them had to be taken into account in making a prognosis about the outcome.

By applying the Form to the case material that emerged in the early interviews, the worker was able to appreciate more clearly whether his relationship with the patient was likely to be a fruitful one. It could be judged in relation to such factors as why and how he came for help, how he responded to the worker, his defences, capacity for

insight, and degree of maturity, as well as the amount of feeling with which the main themes were charged. The sort of material that did *not* emerge would also become apparent, and might indicate areas about which the client felt strongly in a negative way. If both partners came for interviews, discussion between their caseworkers might reveal possibilities of adjustment in the marriage, leading to the necessity of a proper assessment of these; and observation of the repercussions felt *by the family as a whole* might suggest a means of interrupting vicious circles of behaviour. Focusing on the marriage relationship in this way tended, moreover, to prevent either spouse becoming too dependent on his or her worker.

Some clients were offered help over a short period to enable them to surmount a crisis, or to make up their minds about a decisive step that they were contemplating, or to overcome a difficulty that could be worked through in terms of some limited area of personality. Such short-term work might also be offered to clients for whom a fundamental change in attitudes and relationships was judged to be too threatening, or who had no real need for intensive work. Others, who from the outset showed increasing receptiveness to the approach, and who could develop a realistic working relationship in the interviews, were likely to make use of more long-term work. Some clients might reveal in a few interviews a degree of disturbance which suggested that psychiatric treatment might be more appropriate, and the possibility of referral would then be raised. Even those with little insight might be helped to make some adjustment to their personal problem.

Assessment of 'results' was difficult, but a limited appraisal was made by seeing how far, and in what ways, improvements occurred in relation to the potentialities of the case as estimated during the initial interviews. Each case presented a different combination of strengths and weaknesses in three areas of functioning: the marriage, the individual, and other family relationships. In a hundred cases, *fifteen showed marked improvement, twenty-seven considerable* improvement, thirty some improvement, and twenty-eight no apparent improvement. It would have been even more difficult to try to make such an assessment if the early interviews, reported in terms of the Form, had not been available. Unfortunately opportunities for follow-up were not often forthcoming. This, then, was the first application of the Form.

Later, the Form was used by some general practitioner groups at

the Tavistock Clinic, but without much success: possibly because the continuing relationship of the general practitioner and his patient made it less urgent for the doctor to make an early diagnosis; and because any repercussions from the treatment were likely to remain the doctor's responsibility, continuing follow-ups being the rule rather than the exception in that particular setting.

Subsequently, the Focal Therapy Workshop, during the eight years of its existence, gradually developed the Form from the FDB prototype. By the end of the first three years it had, however, become reasonably stabilized, and a typical Form at this stage is shown in the Appendix to this chapter (p. 23).

The main changes made in the original Form were of two kinds, each involving two headings. In the first place, two items were moved to a different position in the FTW Form. Information about referral was taken out of the case-front facts and put at the head of the Form proper, because it was realized that how the referral came about (involving the relationship between referrer and patient, and that between referrer and interviewer) might be valuable material relevant to the process of making a diagnosis, and was likely to produce the first clues about the patient's motivation for treatment. Similarly, the question why the patient had sought help at that particular time was disengaged from the heading dealing with his conception of himself and other important people, and became a subheading in the section concerned with his manner of presenting his problem and his attitudes towards it. These changes, then, were largely a matter of the degree of emphasis that certain parts of the Form might carry.

The second type of change involved the introduction of new headings incorporating useful new concepts. The first of these was the addition of a section describing the course of the interview and important moments in it, such as inconsistencies in the patient's story, or interpretations given by the therapist. The purpose of this was to restore a record of the ebb and flow of the session in roughly chronological order, an aspect that was absent in a catalogue of facts pertaining to the diagnosis. Finally, the most notable development was the enlargement of the summary to include an assessment of the psychodynamics of the case (replacing the assessment of the structure and level of the material, which came under the subheading of 'main themes' in the FDB Form). With this in view, the summary opened with a list of all the ways in which the disturbance was shown in the

patient's life, then the pros and cons in respect of focal therapy could be gradually established.

The technique of focal therapy consisted in identifying an area of the patient's internal life, the readjustment of which might be so significant that it would influence his symptomatology considerably for the better. This led, in turn, to a search for the technical steps necessary to achieve such readjustment, and to an estimate of the time required.

Malan concluded from the work of the FTW that the generally held 'conservative' view, according to which brief psychotherapy was appropriate only to patients exhibiting an illness of not too severe a symptomatology and of fairly recent onset, was not invariably valid. On the contrary, there was substantial evidence that other factors were of greater consequence and that quite far-reaching and lasting improvements could be obtained in relatively severe and long-standing illnesses. Strong motivation for therapy, a good contact with the interviewer, and at least some constructive response to interpretations seemed to be very important for a good outcome.

The 'focus' would ideally be formulated in terms of an 'essential' interpretation on which the therapy was to be based. If the focus crystallized out of the early sessions, the therapy could be planned accordingly; in some cases, however, continued work might show another, more important, focus which would then have to be used, though it meant that time would have been wasted in unproductive work. This was because the technique necessarily involved pursuing the chosen focus single-mindedly, guiding the patient by partial interpretations, with selective attention and selective neglect. If the material admitted of more than one interpretation the therapist would always choose that which was consonant with the chosen focus, and refuse to be diverted by material apparently irrelevant to it, however tempting it appeared.

This technique assumed a successful interaction between patient and therapist which, [illegible]
The doctor, his patien [illegible]
following terms:

'(*a*) the patient offers material, which
(*b*) enables the therapist to formulate a focus, which
(*c*) the therapist offers to the patient, which
(*d*) the patient in turn accepts and works with.'

The preliminary mutual offering could often be seen quite clearly in the initial interview or in one or two subsequent sessions, resulting finally in the identification of a focus on which most of the rest of the therapy was based, and which had to be chosen in terms of what was most helpful to the patient rather than what the doctor found easiest to work with.

The Form was not, however, necessarily tied to the exclusive requirements of focal therapy, and with some modification of the summary paragraph it could have a wider application (see the Cassel Hospital Initial Interview Report in the Appendix to this chapter, p. 24).

The FPA seminar examined the FTW and the Cassel Hospital Forms and concluded, after trying out cases on both, that the FTW Form was more suitable to adapt to its purpose because the summary was designed with a definite view to focal therapy, and the seminar was committed to some type of brief psychotherapy because of the limited time available for treatment.

As marital problems were to be studied, it was decided that the date of the marriage, the age and occupation of the spouse, and the number and sex of the children, should be added to the list of preliminary facts. It was also clear that a subheading on 'predictions' would have to be included in the summary, for the purpose of the research project.

The factual material presented difficulties. It might be thought that this was a matter of simple observations, but this concept was not entirely true, since the chronological order in which the facts emerged might be of great significance and might be better dealt with under a heading covering the course of the interview and important moments in it. As regards the facts themselves, there were two alternatives: one was to press every known fact into what would become a history; and the other was to select only those thought to be relevant to the problem in hand. The former might be more reliable, since an outside observer could decide for himself what was relevant or not; on the other hand, it would involve case-reports of inordinate length. In view of this, the FTW had chosen the latter course and the seminar decided to follow suit, although it involved trusting the doctor to report the material faithfully. It was also thought better that the important moments of the interview should be kept close to the factual material, so these headings were put next to each other.

There was a lot of discussion about how to incorporate a 'physical examination' heading in the form. It was eventually agreed to place it after the 'general course and important moments of the interview' heading, because the examination was always an intervention by the doctor, which stopped the patient's story at the moment when he decided that the time was ripe for it. It was, nevertheless, necessary to bring out the physical side of the picture: a man might have atrophic testicles, and a woman might have vaginismus, and lack of this knowledge might make nonsense of the doctor's conception of the patient's problem. It was not just a question of excluding somatic pathology either, since the doctor might be enabled to see the whole of the previous part of the interview in a different light; for instance, in talking to the doctor a woman might deny her terror of anything entering her vagina, whereas a vaginal examination must reveal it.

In view of the fact that the research was involved with studying marital problems, a special heading was introduced to cover the patient's sexual life, before and after marriage. This was aimed at dealing with his feelings and expectations rather than at recording bare facts, since the latter might be noted under the factual material. What attracted one spouse to another, their feelings about the nature of sexual intercourse, and fantasies associated with masturbation, could be grouped together appropriately under this heading. At the same time, the patient's conception of his spouse would merit a special subheading in the section concerned with his conception of himself and other important people. These two headings followed one another, after the physical examination section.

Finally, the summary paragraph was extended to include predictions as to what changes would occur in the patient's symptoms in a specified time. In the early cases, predictions were made on the basis that:

either (*a*) brief psychotherapy was possible
or (*b*) long-term treatment was indicated.

If brief psychotherapy was deemed possible then further predictions were made as to:

(i) what would happen in a successful treatment, and how long this would take;
(ii) what would happen in an unsuccessful therapy, and why.

The aim was to make these predictions as explicit as possible so that they could be compared with the actual outcome of the cases.

It was realized, however, after the first dozen cases that the kind of prediction that was being made was not definite enough, and could be considered to be somewhat equivocal in half these instances. What was wanted was a firm statement that would stand or fall by the outcome, since only in this way could the validity of this method of assessing the cases be tested. To do this, a list of criteria for a successful outcome had to be drawn up under the heading for predictions, and they had to relate to the focus chosen. The criteria would reflect the changes in the original list of disturbances in the patient's life that would be expected to result from dealing with the pathology in the focal area. In addition, the time required to achieve those changes had to be estimated, and factors militating towards an unsuccessful outcome had to be noted, since they would have a bearing on the appropriate technique.

This summary paragraph completed the Form proper, but a further heading covering the group discussion, with any amendments to the formulation that could be accepted by the therapist, was added for the purpose of the research project, because learning to use the Form was as much a part of the work as assessing its usefulness. The FPA Form, as it was finally evolved, is the last item in the Appendix to this chapter.

APPENDIX TO CHAPTER 2

The Evolution of the Form

FAMILY DISCUSSION BUREAU (FORM A)

Name:
Household
Housing, rooms,
changes since marriage (dates)

Date of Marriage:
Length of courtship
Interval: marriage to first child's birth
Separations (dates)

Case no.
Caseworkers (Husband) (Wife)
No. of interviews:
Referring agency:
Date referred:
Reported back (dates):
Children
Names and ages
Schools, jobs, health problems

LIFE HISTORY	*Husband's* (Age:)	*Wife's* (Age:)
Place of origin		
Education and training		
Religion		
Present employment (previous and dates)		
Health (dates)		
Previous engagements, marriages, children		

PARENTAL FAMILY	*Husband's*	*Wife's*
Parents		
Age now (death and dates)		
Ages at marriage		
Social position and education		
Employment		
Health		
Separations, remarriages, parent substitutes		
Siblings		
Ages and sex (death and dates)		
Employment		
Marriage and children		
Health		

FAMILY DISCUSSION BUREAU (FORM B)

Name: [*Note: Negative findings*
No. of interviews: *must be included*]

A (1) Appearance and manner of client.
(2) Manner of presenting story.
(3) Problem as seen by client.

B Factual material relevant to diagnosis.

C (1) What seems to bring the client now?
(2) Client's expectations and phantasies about coming, and about possibilities of help.
(3) Client's conception of himself.

..... of other important people.

Development of client–worker relation

D (1) Client's positive and negative responses and ways of using worker.
(2) Worker's developing responses to client.

E (1) Main themes, structure, level, and cohesion of material. Points where feeling was shown.
(2) What happened during these interviews between client and worker; what kind of object relation developed; how far was client made aware of his own defences and shown the correspondence between interview pattern and usual behaviour?

Summary

F (1) Worker's impression of real problem and of client's personality: of his methods of coping with or using people; of patterns of object relations; of methods of defence; of degree of maturity; of his insight into his problem.
(2) Immediate aim and steps for achieving it. Ultimate possibilities and limitations.

FOCAL THERAPY WORKSHOP FORM

Name of interviewer:
Name of patient:
Age:
Occupation:

[*Note: State explicitly any negative findings*]

A *Referral*

(1) History and method: how referrer was approached, by whom, etc., and how he approached interviewer.

(2) Relationship of referrer to interviewer and to others involved.

B (1) *Appearance and manner* of patient; manner of presenting his story.

(2) *Complaints*, and patient's emotional attitude to them.

(3) What seems to bring the patient *now*?

C *Factual material* relevant to diagnosis.

D (1) *Patient's conception* of himself.

(2) *Patient's conception* of other important people.

E *Developing doctor–patient relationship*

(1) How patient treated doctor; any change; whether this behaviour threw any light on patient's usual behaviour or on his attitude to illness.

(2) How doctor treated patient; any change during interview.

F *Important moments in the interview*

G *Summary*

(1) Ways in which disturbance is shown in patient's life.

(2) Presumed meaning of above in psychodynamic terms.

(3) (*a*) Suitability for focal therapy, with reasons.
(*b*) Points against focal therapy.

(4) Immediate aims.

THE CASSEL HOSPITAL INITIAL INTERVIEW REPORT

Name of interviewer: *Age of patient:*
Name of patient: *Occupation:*
Date of interview:

A *Referral*

(1) Mode: how referrer was approached; how referred approached interviewer. Data concerning relationship between referrer and patient.

(2) Relationship of referrer to interviewer and to others involved.

B (1) *General description of patient*

How the patient comes (waiting-room contact, whether accompanied, etc.).

Appearance, dress, manner of speech, body expression.

Manner of presenting affects; manner of presenting story.

How the patient 'got going' (help required, if any).

Any further relevant facts.

(2) *Complaints*, and patient's emotional attitudes to them (descriptive terms).

(3) *What seems to bring the patient here now?*

C *Known relevant facts*

The patient's life generally.

The patient's problem(s).

D *Doctor–patient relationship*

(1) How doctor handled patient, with changes.

(2) How patient handled doctor, with changes.

E *Important moments in the interview*

Interpretations given, with responses.

F *Patient's conception of himself*

His conception of other people.

Is there any discrepancy between patient's estimate of self and others, and the doctor's? Has illness changed this conception of himself?

G *Salient character traits of patient* (courage, weakness, cooperation).

H *Assessment of psychodynamics* (briefly, with the level of disturbance).

I *Therapy* (type chosen, with reasons).

FAMILY PLANNING ASSOCIATION SEMINAR FORM

[*Negative findings to be stated explicitly*]

Date of consultation: .....

Name of interviewer: .....

Name of patient: .....

Age: .....

Occupation: .....

Date of marriage: .....

Spouse (age and occupation): .....

Children (with ages): .....

.....

A *Referral* (history and method)

B (1) *Appearance and manner of patient*; manner of presenting his story.

(2) *Complaints*, and patient's emotional attitude to them.

(3) What seems to bring the patient *now*?

C (1) .....

(2) .....

..... shown; cohesion/incoherence of material; important (perplexing, camouflaging, etc.) remarks by patient; what interpretations were given and patient's responses.

D *Physical examination* (findings, patient's behaviour).

E (1) *Sexual development*

(2) *Marriage*

F *Patient's conception of:*

(1) Himself/herself.

(2) Spouse.

(3) Others.

G *Developing doctor-patient relationship*

(1) How patient treated doctor; any change. Did this behaviour throw any light on patient's usual behaviour or on his attitude to *illness*?

(2) How doctor treated patient; any change *during interview*.

CHAPTER 3

The Impact of the Form on the Seminar

The seminar decided to present all new cases in terms of the modified FTW Form, but was allowed freedom to alter either the nature or the order of the headings to suit any given case, with the result that a Form gradually evolved to suit the particular type of work the seminar was doing. By the time half the cases discussed in this book had been presented, the definitive FPA Form (as given on p. 25) had crystallized.

There was no compulsion to apply the Form after any given interview, though it was thought a good working rule to apply it to the material after the initial interview, and in so doing to assess what had emerged about the patient and what remained obscure. Thus at the next interview the doctor would be aware of the gaps in his knowledge or understanding of the patient's problems, and so might be able to draw out the patient in order to evaluate whether the obscurity was dictated merely by insufficient time for the material to have appeared, or whether it represented a resistance on the patient's part. The record would then be reformulated in terms of the Form, and it was thought that this should be done after not more than three interviews to avoid the danger of the doctor's becoming involved beyond his competence in a case. Avoidance of this risk was one of the objects of the method to be tested in the research.

At this stage, when the doctor had a clearer picture of what were the patient's main problems, the diagnosis had to be put to the test to see whether the insight gained by the doctor was therapeutic for the patient. This could be done by giving one or two interpretations at the appropriate level and noting what the patient did with them. If the patient rejected them or ignored them, then the prospects for brief psychotherapy were thought to be poor. If the patient accepted them and used them constructively, then something might be achieved in a reasonable time.

This idea of a limited, but, as far as possible, precisely planned,

approach was based on the premise that the doctors would know in advance what they were trying to do. Even so, every failure could not be blamed on the patient; the doctor's technique would also have to bear criticism. This might be unpleasant, but it was a duty that could not be shirked by the seminar, and any criticism offered would, of course, have to be freely accepted by the doctor concerned before it could be incorporated in a reformulation of the case.

The possibility that a prediction might actually influence the course of the therapy had also to be considered, especially if a bad prognosis was given for a case, since this might have the effect of disheartening the doctor. It appeared, however, when the outcome of the cases came to be studied, that this factor had not constituted a problem in practice.

Some difficulty arose because the doctor had to do two things at once. The Form was intended to organize the material and to summarize it at the same time. The story had to be told to make the patient 'come alive', but this had to be done in a very condensed manner. Reading a condensed report, in comparison with hearing a full one from the lips of the doctor treating the case, meant that the colour was lost, and the group's contribution to the formulation of the case was more limited. On the other hand, the method made the reporting of a case a much less long-winded affair. The chief danger here was that the Form might produce a string of facts without any apparent dynamic connection between them, and the group would in consequence be unable to observe the interaction between the doctor and the patient, except through what the doctor reported and deduced in writing, instead of being able to visualize his involvement through his oral report (in the old method the doctor was often seen to 'act' the patient). Another danger was that the doctor might just produce the story and expect the group to do the deductive and critical work on the case, whereas one of the aims of the Form was to compel the doctor to do this himself in producing the report, and in so doing enable him to use this deduced material for constructive criticism. The Form was, in fact, a conceptualization of everything that happened, recorded under certain definite predetermined headings, and, when all this had been taken into consideration, a much more accurate assessment of the patient's possibilities for treatment might emerge, as well as an indication as to the appropriate technique. When this assessment had been made and the focus had crystallized,

the doctor might proceed with therapy ruthlessly related to the focus selected, while constantly bearing in mind the factors that might adversely affect focal therapy. Thus, firm and steady interpretations in terms of the focus might proceed, with the doctor freed from apprehension by knowing what he wanted and going for it. This was the essence of the technique.

However, the seminar also had to take into account that the data obtained would depend on the quality of the instrument that recorded them, and in the present project the doctor was just that. The Form would show up his faults, but this was the only way that progress could be made. Its use would be time-consuming initially, though the therapists in the FTW had found that, with practice, a report could be produced in about twenty minutes.

Other less vital issues had to be considered as well. Repetition had to be avoided, and the more factual first part of the Form should account for only about half the total length of the report (excluding the summary) to ensure adequate reporting of the interaction between the patient and anyone important within the context of the case (including the doctor) in the second half.

It cannot be said, then, that the members of the seminar were left without serious doubts and misgivings about the undertaking. There was general assent that the use of the Form made the doctor look at the interview in an orderly way after its conclusion, and that the report was tidier, but there was also a unanimous feeling that it was not so alive; something seemed lost among a welter of headings, and it had to be decided whether this loss was vital, or whether it was merely a feeling due to unfamiliarity with the mode of presentation.

In the past the seminar had been used to having the material raw, and now the doctor had to produce a carefully formulated report such that some of the members of the seminar felt themselves incapable of criticizing. There was no doubt that the old method was much easier, though Michael Balint had warned the seminar that everyone was bound to dislike the discipline imposed by the Form until he became accustomed to its use. Nevertheless, dislike of the Form grew so strong among the members of one group that it came to be felt that this way of reporting was unsuitable for its method of working. The group considered that a minimum amount of professional skill was necessary for a doctor to undertake a special type of work, and that, since the members seemed to lack this while using the

Form, it would be unprofessional to continue with the method. They felt that they were being asked to do the work of psychiatrists, for which they were not qualified since they lacked the necessary ability and training.

Balint put the view that the doctors were doing psychiatric work anyway, and that it would be professional to discover what sort of psychiatry it was. He also thought that one possible way to do this would be to ask the doctors to accept the discipline of reporting their cases in terms of the Form, the first purpose of which was to make sure that they were not going outside their ambit of competence in treating the patients. Making an early diagnosis and planning the therapy to achieve a definite result were means of protecting the patient from the dangers that might arise if general practitioners acted in a consultative setting, and he, as the supervising consultant psychiatrist in charge of the whole project, would be in a better position to follow the individual therapies.

There was no question but that the other group who were welcoming the Form were becoming more psychotherapeutically minded, getting farther and farther away from the direct physical contact with the patient that had produced excellent results in the cases of non-consummation. The women doctors of the original FPA seminar had allowed their women patients to speak through their bodies, as it were, and this technique was being left behind, though it could be that the group using the Form might eventually have to admit that they could not do very much for the patient, remembering that the FDB caseworkers had found their technique unsuitable for treating unconsummated marriages.

Alternatively, it might be that the group who resisted the Form did so because they could not help applying its discipline *during* the conduct of the interview rather than, as befitted its proper role as a sensitive recording device, when the patient was no longer present.

It was finally agreed that one group of the seminar should revert to the old method of working, and study specific problems such as frigidity. The work of this group is reported elsewhere. The group using the Form proceeded to test its usefulness in diagnosis and treatment in the special setting in which the doctors operated. One member of each group decided to attend the meetings of both groups.

The group that continued to report in terms of the Form decided to arrange in advance which doctors were to report a case at the next

meeting; and their reports were to be sent to the seminar secretary in time to be appended to the typewritten transcript of the proceedings of the previous meeting, copies of which were distributed to the members at least a day before the group met again. In this way every member could read the reports prior to the meeting. This arrangement had the advantage of saving time, but it also had a disadvantage in that it assumed that all the members had reached approximately the same level of sophistication and reliability. It was further decided to restrict the number of new cases to be discussed, so that a thorough follow-up on each could be achieved. This decision, by excluding some of the current cases, had the unfortunate effect of destroying the possibility of a truly random sample.

The group appointed the author as record officer, whose duty it was to keep cards recording the summary of every case as amended by the group discussion. The card was to show at which meeting of the group the record was made. Follow-up observations and subsequent secondary predictions were to be noted, and the officer was charged especially not to allow the final formulation of the summary to remain incomplete, or, if completion were thought impossible, to specify reasons why. He also had to remind the doctors to produce follow-up reports at intervals dictated by the original prediction, in terms of the time necessary to achieve the planned change in the patient. Finally, on the termination of a case, the outcome and the group's comments on it were also to be recorded.

In the subsequent chapters, some of the cases treated by the group are presented in detail, and all the cases are later considered on the basis of their summaries, so that the outcome of all of them is assessed, and the effectiveness of the discipline of the Form evaluated.

During the period of the research, thirty-four cases were brought up for discussion by the seminar. In seven of these cases, assessment in terms of the Form was found to be impossible on the evidence available. The remaining twenty-seven cases were formulated, and twenty-two were accepted for treatment. The criteria of selection are examined in Chapters 7 and 8.

CHAPTER 4

How Brief is Brief?

In the next three chapters I have tried to present as accurate a picture as possible of the group's method of recording and working in terms of the Form; it will be seen that even a small number of cases requires a good deal of space.

This chapter deals with two cases, which illustrate, respectively, treatment lasting less than ten sessions and treatment lasting more than ten. The group arbitrarily decided that if a case appeared at the outset to be likely to need more than about twenty to twenty-five sessions it should not be taken on for brief psychotherapy in the FPA clinic, since this represented about 15 per cent of a doctor's time there in any one year. The limited time available would allow only three or four patients to be seen by each doctor on a weekly basis, and it was precisely this pressure that had led the doctors concerned to try to improve their diagnostic skill by using the *Form* method of recording cases.

The most common treatment situations in FPA clinics at the time the project began are presented in this chapter: namely, a case of frigidity being treated by a woman doctor, and a case of impotence being treated by a male doctor. The reason for the frequency with which this pattern occurred was more historical than medical, since the need to tackle psychosexual problems in the FPA setting had emerged in the course of the giving of birth-control advice to women by women doctors; and, when this service had been developed on a more specialized basis, the needs of the husbands had also to be taken into account, and were usually met by men doctors. The two patients discussed here were not, in fact, married to each other, but were 'half-couples' whose spouses were not directly involved in treatment. The interesting fact was that most of the men were referred to the FPA from other agencies, probably because there was a great lack of facilities for treating impotence, and also because men often

did not wish to approach their general practitioner about this sort of complaint.

All the doctors and patients have been given pseudonyms, though the sex of the doctor has been indicated, because this had a bearing on the technique adopted. The relevance of this factor and of other treatment situations is discussed in subsequent chapters.

MRS DRYDEN

A PRELIMINARY FACTS

1 *Doctor:* Dr North (Female).
2 *Patient:* Aged 34. Married four years.
Physical training instructor before marriage.
Spouse: Aged 33.
Dentist.
Children: Two, aged 3 and 1.
3 *Referral:* By her general practitioner, whose letter stated: 'Very intelligent couple who seem happily married in every way and well suited to each other, but to their sadness and surprise she has never reached an orgasm.'

B THE PRESENTATION

1 *Appearance and manner*
Seemed alert and intelligent, but there was a hint of tenseness under a façade of calmness.
2 *Complaint*
She had never achieved an orgasm, but was insistent that everything else in the marriage was wonderful.
3 *What brought the patient then?*
Presumably the unbearable tension of sexual frustration.

C 1 FACTUAL MATERIAL RELEVANT TO THE DIAGNOSIS

The patient was fond of both parents, though there was disharmony between them, which she insisted was merely over their differences of religion. She saw her mother as more tolerant, and her father as very strict, but felt unable to talk to her mother about important things in case it provoked an outburst of parental altercation, which always resulted in her mother trying to dominate her father. In consequence, she tended to withdraw and become aggressive to

both parents, which gave her feelings of guilt. She had a sister, who was much older, whom she admired at a distance. She was sent to boarding-school at thirteen, after which she trained to become a physical training instructor, eventually working in a rehabilitation centre. She liked working with patients when she could influence them and help them to get better, but disliked those patients who were unable, or unwilling, to make use of the training programme in their recovery, feeling they were not amenable to her approach.

2 GENERAL COURSE OF THE INTERVIEW AND IMPORTANT MOMENTS

The patient seemed very anxious to cover up her resentment against her parents and husband, and expressed guilt when such feelings emerged; she tried to resolve this situation by retiring behind a screen of generalizations. The doctor rapidly became aware of the patient's need to hide her very strong feelings, and realized, as the interview developed, that she could not accept interpretations involving these aggressive feelings towards her parents, and so was forced into trying to dominate the doctor. On the other hand, she appeared to relish interpretations involving aggression towards her husband, revealing a keen urge to punish him even to the extent of refusing a very good part-time job, which might have been a satisfactory outlet for her need to control people. She accepted an interpretation of her narcissistic feelings connected with her work.

D PHYSICAL EXAMINATION

No vaginal examination done.

E SEXUAL DEVELOPMENT AND MARRIAGE

1 *Premarital*

She showed a reluctance to grow up, especially at the time of puberty. She found the parental disharmony intolerable because of the strength of her own feelings, but apparently felt pleasure in controlling these by escaping into fantasy. She dreamed of a heterosexual relationship with an imaginary older man, which was exciting, but guilt-ridden. She did not have a real boy-friend until she was twenty-four. She had a lot of sexual excitement with him, and even an orgasm during petting, but broke off the relationship because they disagreed too much, and she could not tolerate that.

2 *Marital*

She had a long, intermittent friendship with her husband, whom she found placid and unexciting. They had no passionate kissing or petting until four months before they were married and she had never had sexual pleasure with him in reality, though much in her imagination. She seemed happy only when her husband was doing what she wanted, and, being jealous of his masculinity, tried to push him into doing feminine jobs to help her, and became infuriated when he evaded them. She seemed to idealize the marriage, though she was reluctant to accept her femininity, being unhappy when she became pregnant, and tending to vent her discontent on her children.

F CONCEPTION OF SELF AND OTHERS

1 *Self*

Considers herself as a loving wife with too much to do.

2 *Spouse*

She thinks she has too little sympathy from her husband, who does not fulfil her expectations, being clumsy and unhelpful.

3 *Others*

Feels ambivalent towards her parents, and cannot readily own the hostile component. She is also very jealous of her mother-in-law, a widow, whose only daughter is in Australia, because her husband feels very responsible for his mother. She thinks her children are wonderful, but also very irritating and demanding.

G DOCTOR–PATIENT RELATIONSHIP

1 *How the patient treated the doctor*

The patient clearly expected sympathy and seemed puzzled that the doctor should want to explore the part she played in the unsatisfactory marital situation. She resisted interpretations bearing on her responsibility.

2 *How the doctor treated the patient*

The doctor was impatient of her idealization of everything, and gradually toughened her attitude in an attempt to make the patient face up to the realities of the situation.

H SUMMARY (as amended in the light of the group discussion)

1 *Ways in which the disturbance is shown*

The patient was often critical and resentful, but had pleasure in controlling these feelings. Presented as a failure to accept a feminine role, with a neurotic need to involve her husband in feminine duties, and anger when he resisted this pressure. Showed denial of what she was doing in her own marriage, but showed anxiety about her parents' marriage, though she denied this anxiety when challenged. Had a generally negative attitude to everything. Thought that external changes would solve her difficulties. Suppressed her aggression and idealized everything.

2 *Presumed meaning of the above in psychodynamic terms*

Shows strong narcissistic feelings, frustrated at the homosexual level because of difficulty in resolving the Oedipal situation. *Deep insecurity due to parental disharmony, with a consequent need to keep everything under control.* Jealousy of the masculine role, with a resultant neurotic need to punish her husband. Identification with mother, so that men exist only in terms of being controlled and denigrated. Feels inadequate.

3a *Points in favour of focal therapy**

(ii) Reasonable ego-strength.
(iii) Reasonable relationships.
(iv) Recent exacerbation.
(vii) Her narcissism is readily identifiable in spite of being concealed. Fantasy fears of breaking up her parents' marriage.

3b *Points against focal therapy**

(i) Narcissism (disturbance centred at pregenital level).
(iv) Lifelong disturbance.
(vi) Wants help only on her own terms.
(viii) Strong resistance to interpretations.

4 *Focal aim*

She should be allowed to become somewhat depressed at the realization that she might wreck her own marriage by repeating her own parental patterns. *Clear focus.*

5 *Prediction*

She will change her attitude to her mother through the transference situation, but her self-idealization will remain unsolved.

Criterion of success

She would lose her resentment at her lack of reaching orgasm.

*Roman numerals under 3a and 3b throughout case reports refer to the selection criteria described in Chapter 7.

I SUMMARY OF THE GROUP DISCUSSION

It appeared that the patient was reliving her parental marriage pattern in her own marriage. She had identified with her mother's struggle without ever being able to get in touch with her own femininity, because she feared causing more trouble between her parents. There was a great danger that treatment by a female doctor might degenerate into just such an unsatisfactory relationship. She felt inadequate as a woman, despite her feminine appearance, which was merely a mask to cover her inadequacy. She even seemed to be straining after a male type of orgasm. The question was whether her need to dominate was a result of anxiety or of something more essential to her. She would become depressed if she was unmasked, and if she then became aggressive some constructive changes might occur in her attitudes towards herself, her mother, and her husband. If the depression became severe, long-term treatment would be necessary.

J SUMMARY OF THE COURSE OF THERAPY

At first, the patient expressed disappointment at not having won the doctor's sympathy, but this was obviously said with veiled resentment. She then felt better, briefly, having four intercourses in a week, but without pleasure; subsequently she became depressed (with the air of a martyr) when the doctor challenged her idealization. The doctor then accepted her underlying unhappiness, and this allowed the patient to bring out her anger and resentment against her parents.

It transpired that her mother had forced an enema on her when she was very small, which had been an exciting and humiliating experience; the memory of this was evoked by her husband touching her clitoris, though she enjoyed the foreplay of intercourse. Her father had frowned on all her boy-friends, although she knew that he had been a gay dog as a youth, and she was resentful that he should be so repressive in imposing his changed attitudes on her before she had had the chance to make a free choice.

She realized that she had married her husband because she felt that he represented the best in both her parents, and became angry with him when he did not match up to her idealization.

The doctor felt how difficult it was to deal with this patient who idealized everything, became excited by these ideal fantasies, and

then became disappointed when they were not realized. This was interpreted, and the patient broke down in tears, saying all she wanted was the ability to experience orgasm. The doctor interpreted this childish attitude, and the patient became very angry, but she realized that this was just the way she used to react with her mother.

Subsequently she became able to have intercourse with pleasure, though she did not feel that she had actually experienced orgasm.

K OUTCOME

Nine interviews in all, one before presentation on the Form.
Three group discussions, after the first, third, and ninth interviews.
Successful outcome.

This was a successful treatment in that the patient lost her resentment at the absence of orgasm. The doctor had succeeded in diminishing her need for idealization and she had become able to recognize some faults in herself. Her first reaction was depression, but this rapidly changed into aggressiveness, which apparently led to some liberation, and she had been able to enjoy intercourse if not actually to have an orgasm.

The early progress was quicker than predicted, because the patient's initial depression rapidly gave way to expressed resentment, first towards the doctor and then towards her parents. There seemed no doubt that she had been able to change her attitude towards the latter, and this had arisen out of the transference relationship in which the doctor had been given the mother's role. The patient had been able to gain insight into the fact that if she cried for an orgasm like a child she would not have one, and that pleasure lay in giving herself to her husband and accepting what he gave her.

The points for and against focal therapy seemed fairly evenly balanced, so that the correct handling of the transference was the key to success. The group thought that the patient might indeed achieve orgasm.

MR ENFIELD

A PRELIMINARY FACTS

1 *Doctor:* Dr Pinner (Male).

2 *Patient:* Aged 50. Married sixteen years.
Buyer in textiles.
Spouse: Aged 39.
Secretary before marriage.
Children: Three, aged 15, 13, and 7.

3 *Referral:* By his general practitioner, whose letter stated that the patient had only lately come under his care but had been complaining of loss of libido for more than a year. He had previously been referred to an endocrinologist, and no abnormality had been found. Testosterone had, however, been tried, without benefit. The doctor concluded that the trouble was psychological and asked for an opinion.

B THE PRESENTATION

1 *Appearance and manner*
The patient was a tall, lanky, fresh-faced man, who talked easily and was apparently trying hard to communicate his problem.

2 *Complaint*
He complained of intermittent loss of libido over the last three years. He had been able to achieve intercourse for some months at a time, but without ever experiencing urgent desire or a great deal of satisfaction.

3 *What brought the patient then?*
Came on the general practitioner's advice, after endocrinological investigation and treatment had proved unhelpful.

office; and occasionally he had indigestion while at work, especially if he had been needled by someone. He had achieved intercourse a few times since the referral had been initiated, but always dutifully rather than because he had much sexual desire.

2 GENERAL COURSE OF THE INTERVIEW AND IMPORTANT MOMENTS

He told a very cohesive story and was not overtly anxious, but was always insistent that the doctor should understand the facts exactly, and was constantly making minor corrections to attempted interpretations. He was quite sure that the trouble was unconnected with his work, and utterly rejected interpretations involving his professional success or failure. He showed most feeling when talking of his elder son's difficulties at school, and accepted an interpretation that he felt a failure as a father.

D PHYSICAL EXAMINATION

Not thought appropriate in view of the previous investigations.

E SEXUAL DEVELOPMENT AND MARRIAGE

1 *Premarital*

He had had several affairs before he married, in which intercourse had been satisfactory, though they seemed to have been of an experimental nature and there was no evidence of any very deep relationship in any of them.

2 *Marital*

He had met his wife in India when on his way to active service in Burma. She was the daughter of a family who had previously entertained a friend of his. She was eighteen when he met her and he found her very attractive, though in fact he hardly had a word in private with her during his stay. He wrote to her, however, and they became pen-friends, and eventually he proposed to her in a letter and was accepted. He insisted that she come to England to get married, though she nearly called it off soon after her arrival. Intercourse had been satisfactory in the marriage until the trouble started three years previously.

F CONCEPTION OF SELF AND OTHERS

1 *Self*

Considered himself a reasonable man being thwarted by an illness.

2 *Spouse*

Very fond of his wife, who was still very tolerant of his disabili
He had no reservations about his attitude.

3 *Others*

His parents kept an off-licence, and he was the second child of fi
boys. His father had always seemed remote to him as a child, ar
the patient felt that he had got to know him only after his mother
death, which occurred suddenly, shortly before his own marriag
He had been very close to his mother and was heartbroken at h
death. He got on well with all his brothers and they had stuck t
gether before they married.

His daughter was doing very well at school, and was helpful an
responsible at home; whereas his elder son was doing very badly a
school, the reports saying that he was clever, but idle. He punishe
the boy by withholding treats, but his strict attitude seemed t
rebound on him rather than to discipline the boy.

G DOCTOR–PATIENT RELATIONSHIP

1 *How the patient treated the doctor*

He seemed to assume that the doctor must know his business, bu
could accept interpretations only in an intellectual sort of way, and
strong feeling appeared to be absent. He still considered his illness
to be organic.

2 *How the doctor treated the patient*

The doctor initially assumed that the patient saw his illness as
psychological, having regard to the general practitioner's letter of
referral. He thought that the patient was resistant to interpretations
until he realized that preliminary work had to be done to demon-
state to the patient the real nature of his disturbance.

H SUMMARY (as amended in the light of the group discussion)

1 *Ways in which the disturbance is shown*

Loss of libido. Loss of appetite, especially at home. Loss of confi-
dence in his professional capacity. Absence of feeling in his
relationships, unless the object threatened to withdraw (as in the
case of the death of his mother, and when his son rebelled). Unable
to cope with his son's rebellion, applying increasing force with
decreasing effect.

2 *Presumed meaning of the above in psychodynamic terms*
Narcissistic. Wants everyone to do things his way, or he is not interested. *Depressed, with underlying aggressiveness.*

3a *Points in favour of focal therapy*
(ii) Good ego-strength.
(iv) No previous breakdown.
(vi) Good motivation.

3b *Points against focal therapy*
(i) Narcissism.
(iii) Mixed quality of relationships.
(iv) Lifelong disturbance.
(vii) Restrained cooperation with doctor.
(viii) Resistant to interpretations – rigid personality structure.

4 *Focal aim*
To work with the depression and the underlying aggressiveness, using the faulty relationship with his son at first, and then extending the work to include his wife. *Diffuse focal area.*

5 *Prediction*
If he can accept psychotherapy quickly his aggression will be liberated within fifteen interviews. Otherwise, long-term treatment will be indicated. Doubtful result.
Criteria of success
Restoration of libido and appetite. Gradual improvement in his son's school performance.

I SUMMARY OF THE GROUP DISCUSSION

The referral epitomized the difficulties involved in taking a patient on for psychotherapy. The referring doctor had made a sound diagnosis. The patient wanted help so badly that he was prepared to attend a clinic for marital problems, though he did not admit to such problems, and yet was totally unprepared for a psychological approach. Having been investigated for an endocrine defect and then prescribed hormone treatment, even though no such defect had been found, he had been led to expect a somatic approach. The referring doctor had not worked with him sufficiently to help him to reorientate himself to appreciate the real nature of his problem, and the treating doctor wasted time at the beginning because he did not realize the true facts of the situation. The patient came to understand the position only through his son's difficulties, which

illustrated that bad performance might not necessarily be the product of somatic illness.

Nevertheless, his loss of libido had occurred earlier than his son's depression, though the two problems appeared interrelated in that he seemed to regard his son as a rival, the loss of potency seeming to be a common denominator (his method of wooing indicated shaky potency from the start).

It was thought that the patient was unable to express aggression towards his wife, and could express it only ineffectively towards his son, and so, having no outlet for his aggressive feelings, he turned them inwards on himself and became depressed. Instead of attacking the most important people in his life, he lost his appetite and his libido. However, appropriate as it was to start by dealing with the relationship with his son, it did not seem that this would lead to a satisfactory solution unless the marriage was brought more directly into the treatment.

Furthermore, the fact that the patient had opted for sessions at fortnightly intervals was seen as a covert expression of his underlying aggression directed towards the doctor, which the latter had not appreciated. If this was allowed to continue the treatment would degenerate into an unproductive exchange in a polite key.

J SUMMARY OF THE COURSE OF THERAPY

At the interview following the group discussion the patient had difficulty in making up his mind when he could manage to come for the next session, and this was interpreted by the doctor as an expression of the patient's anger towards him for not dealing adequately with his main problem. The patient at once became anxious and placating, and this was interpreted as anxiety in case the doctor became angry and rejected the patient. The patient was able to accept this, and immediately began to pour out a catalogue of his frustrations. In every department of his life nothing seemed to be going right, and yet he seemed powerless to influence conditions for the better. In his new employment his initiative was constantly thwarted by conservatism among his colleagues and lack of support from his superiors. His son was wasting his talents at school by being idle and uncaring; and his wife bore the double responsibility of having urged the patient to join his present firm and of shielding his son from some of his wrath. Even her timetable did

not allow him a quiet sit down with the paper and a glass of sherry before the evening meal, and yet at the same time it was perfectly reasonable that the children should have their meal as early as possible.

From this time on the patient was able to report steady improvement in all spheres of activity. The colleague whom he had thought most reactionary had come out in open support of one of his new policies; his son had had a better, though not glowing, report from school; and he had found intercourse enjoyable again (he had really wanted it again when away on holiday).

After twelve sessions the patient reported that he felt well, although there were frustrations at work which he now understood to be related to his becoming angry if the possibilities of any given situation were seen not to be developed to the full. He recognized that if he could find a constructive outlet for his aggressive feelings he would not get depressed.

A test of his appreciation of the problem presented itself immediately, in that his rather idealized daughter did badly in her examinations and wanted to leave school early. After initially becoming irritated by her attitudes, he was able to get in touch with her distress and to use his drive to help her in a kindly and constructive way.

K OUTCOME

Fourteen sessions in all, two before presentation on the Form.
Two group discussions, the first after two interviews, the second after eight.
Successful result.

All the criteria of success were met, in that there was restoral of libido, a return of appetite, and improvement in his son's school report. On the other hand, the patient remained under a good deal of stress.

In the professional sphere the reasons for his lack of confidence had been understood, though a completely satisfying solution continued to elude him, because his aggressive feelings still did not always have a constructive outlet.

Nevertheless, it was clear that his depression had lifted, allowing him to enjoy life more, even though his deep-seated narcissistic attitudes remained. His good ego-strength had helped him to withstand the present illness, although his rigid personality structure

precluded a radical change. He seemed to have become more responsive to interpretations during the treatment, however, and this had been a major factor in its success.

The course of the therapy had kept fairly close to the focal aim of working with his depression and underlying aggressiveness, but the initial break-through had occurred in terms of his professional life, which had opened up the possibilities of understanding his problems within the family and the marriage. He defended his idealized view of his wife, apart from some trivialities, throughout, and this remained the least satisfactory part of the treatment.

He had indeed accepted psychotherapy quickly and his depression had lifted within the specified time, but no doubt was left in the doctor's mind that a radical change was possible only in terms of long-term therapy. The doctor had identified himself too closely with the patient at first, possibly because of sharing the feeling that plain fare was dull, so that appetite was stimulated only by something exotic; and this had made it difficult to recognize the underlying aggression that was an essential part of the patient's approach. Somewhat belated interpretations on this theme had allowed another level to be reached, but the nature of the patient's relationship with his wife remained something of a mystery to the end. This prevented the success of the treatment being unqualified, even though improvement had occurred in all the predicted ways.

CHAPTER 5

One Couple—Two Doctors

The cases reported in the previous chapter illustrated the simplest of the doctor–patient relationship systems, in that the patients were seen as individuals complaining of symptoms related to the marital relationship, rather than in a more complex treatment situation designed to include both partners of the marriage.

In the present chapter two further cases illustrate the treatment of both spouses in parallel, by different doctors working together in the same clinic. The doctors concerned were particularly interested in treating marital problems in this setting, and there was close professional cooperation between them. The cases were discussed between the doctors, but in such a way that no actual *material* produced by one spouse ever reached the ears of the other. Thus a completely confidential setting continued to be provided, while at the same time the *doctors* gained insight into the interaction between the marriage partners, and were able to use this in the treatment of the individual patients.

The value of seeing both partners in this way is demonstrated in the two cases described below. It became clear that each of the patients had to find a partner who was uncertain as to his or her sexual identity, and yet each expected to get support from the other in combating the resultant fears.

Once the simplest system is abandoned, a wide range of interview techniques opens up. A fairly common one in general practice is for one doctor to treat both spouses, separately or together, though difficulties may arise through the doctor's identifying with one partner more than the other, which may lead to the withdrawal of the patient who thinks the doctor is siding against him. The advantage of seeing the partners together is that the interaction between them can actually be observed by the doctor, though interpretations that are equally meaningful to each patient may be more difficult to frame.

An extension of the technique of one couple–two doctors, whereby all four persons concerned were present at one interview, developed from the earlier combinations described, and here the interaction between the doctors led to further insight by both doctors and patients.

MR COLINDALE

A PRELIMINARY FACTS

1 *Doctor:* Dr Pinner (Male).
2 *Patient:* Aged 31. Married four years.
Clerk.
Spouse: Aged 23.
Secretary before marriage.
Children: One, aged 2; another expected.
3 *Referral:* By a doctor working in an FPA clinic, who had seen the wife first and had then seen the husband by special appointment.

B PRESENTATION

1 *Appearance and manner*
The patient appeared rather unprepossessing. He also looked intensely uncomfortable, but told his story in a clear and orderly way.
2 *Complaint*
He had become impotent when his wife had wanted intercourse more often than he felt inclined.
3 *What brought the patient then?*
His misery at his impotence, together with guilt about his wife's distress.

C 1 FACTUAL MATERIAL RELEVANT TO THE DIAGNOSIS

Since the birth of their child, his wife had become dissatisfied with sexual intercourse only once a fortnight. His sexual performance had suffered in consequence; first, he had premature ejaculation, then loss of erection, and finally loss of libido. His wife now upbraided him for his impotence, but in a way that clearly revealed that she feared she had become less attractive sexually. In spite of the difficulties, however, he had managed to impregnate her again.

He was the third of five children, the other siblings being 'paired'

so that he had always been isolated and this had made him very independent, living his life in his own way from an early age.

2 GENERAL COURSE OF THE INTERVIEW AND IMPORTANT MOMENTS

He worked honestly in the interview and was clearly asking for help. His air of discomfort appeared to be compounded of a mixture of resentment and guilt rather than overt anxiety.

It was interpreted that he became impotent when he ceased pleasing himself and tried to placate his wife. He accepted this, saying that he did not wish to be unkind to her but could not brook interference in his own private world of feeling.

D PHYSICAL EXAMINATION

Did not appear relevant.

E SEXUAL DEVELOPMENT AND MARRIAGE

1 *Premarital*

He had very indefinite masturbation fantasies, and no guilt about masturbation itself. He had had very few girl-friends, or even acquaintances, let alone a serious love-affair.

2 *Marital*

Attracted to wife who seemed to have a lot in common with himself, including the same sort of personal difficulties. He thought he could help her to solve them with his support and experience.

F CONCEPTION OF SELF AND OTHERS

1 *Self*

Sees himself as a man who will make good if left to his own devices, but who cannot bear to be hurried or bossed, especially by women.

2 *Spouse*

Thinks of her as needing special care and attention, and a great deal of help, but now doubts his ability to supply these since she has become more demanding.

3 *Others*

He considered his father charming and ineffectual, completely run by the rest of the family, especially his mother. He thought of her as a powerful, controlling person, who ruled the family. He did not get on well with any of his siblings, who orientated themselves into pairs and left him alone.

G DOCTOR–PATIENT RELATIONSHIP

1 *How the patient treated the doctor*
The patient approached the doctor very much as man to man, in league against the women (wife and colleague). He remained very cool throughout the interview, though was obviously not insensitive to the situation.

2 *How the doctor treated the patient*
The doctor felt that the patient was somehow a very pathetic figure, but found it very difficult to make any kind of warm contact with him because he was so withdrawn into his own world.

H SUMMARY (as amended in the light of the group discussion)

1 *Ways in which the disturbance is shown*
Has a preference for helpless women, but withdraws if they become dominating. Became impotent when wife's sexual desire outran his own.

2 *Presumed meaning of the above in psychodynamic terms*
He experiences any demand by women as a threat to his masculinity, projecting it into them and hating it resentfully.

3a *Points in favour of focal therapy*
(i) Disturbance at the genital level.
(ii) Reasonable ego-strength.
(iv) No previous breakdown.
(vi) Wants to come.
(vii) Good contact.
(viii) Responds to interpretations.

3b *Points against focal therapy*
(iii) Attitude to women, both helpless and demanding, deeply ingrained in his personality. No good relationships.
(vi) Involved in treatment by wife and wife's (woman) doctor.

4 *Focal aim*
To put him in touch with his masculine feelings, and so enable him to stand up to women. *Clear focus.*

5 *Prediction*
He should be able to enjoy more frequent intercourse fairly quickly, and this might lead to an ability to dominate his wife without her being resentful. The first phase would be attained in eight to ten sessions, with a longer second phase of doubtful duration if

improved situation to the fact that his wife's pregnancy was making her less sexually demanding. The covert aggression towards the doctor was interpreted and this produced the first show of feeling in the patient, who associated his feelings towards women with a boyhood memory of how his favourite suit was sent to the cleaners by the school matron, and another one was returned to him in error. The matron did not believe that a mistake had been made, and his mother did not support him, so the suit was lost. In turn, it was interpreted that women could not be trusted with things men valued, and this was accepted. The patient wished to be seen at intervals of two weeks, but the doctor suggested that weekly meetings might be more in keeping with the limited time available before the baby was born. The patient then threatened to withdraw from treatment, and it was interpreted that he was withdrawing from the doctor's demand, as he did from his wife's, and this was accepted.

He soon reported being able to meet his wife's sexual demands, and even when he had premature ejaculation on one occasion she had been sympathetic, so the anxiety about failure was receding. This improvement had to be drawn out of him, however, rather than being reported spontaneously and with satisfaction. This was interpreted as showing his lack of confidence in his reserves of potency, to which he admitted.

There was indeed a hint that he might enjoy keeping his wife and the doctor under control, by not giving too much away, and this was confirmed by the emergence of anxiety that he might relapse after the birth of the baby, when his wife's demands might increase again. He sought to terminate the treatment while at the same time making sure that a follow-up would be arranged at a time after the baby was born, so that the doctor's support would not be too difficult to enlist in case of renewed difficulty.

It was pointed out that in a way he invited hen-pecking by offering himself as a weak cock, while at the same time hoping that the hen would resist the temptation, and that it was up to him to see that this did not happen. He seemed able to accept this and the treatment was terminated by mutual agreement.

K OUTCOME

Nine sessions in all, one before presentation on the Form.

Three group discussions, the first after two sessions, the second after five, and the last after eight.
Successful treatment.

The prediction about the completion of the first phase was accurate, though change in the deeper disturbance was less certain.

The treatment nearly came to grief because the doctor invited being given a mother-role at one point, rather than the man-to-man relationship the patient sought and seemed to need. As the treatment proceeded, it emerged that the patient tried to deny any desire for women by pretending that they were all unattractive, but at the same time his wife's warmer attitude to him, especially when he was depressed by failure, allowed him to discover his affection for her.

He had then achieved more frequent and enjoyable intercourse, responding to his wife's desires, and seeing them as acceptable stimulation rather than as threatening challenges. Whether he had achieved the ability to dominate his wife, without arousing her resentment, was clouded by the fact of her pregnancy, which made some sort of equilibrium apparently more easy to achieve.

However, more information on this aspect is available in the report of his wife's case, which follows, and in the follow-up reports in Chapter 9.

MRS COLINDALE

A PRELIMINARY FACTS

1 *Doctor:* Dr Latimer (Female).
2 *Patient:* Aged 23. Married four years.
Secretary before marriage.
Spouse: Aged 31.
Clerk.
Children: One, aged 2; another expected.
3 *Referral:* The patient brought a long letter from a doctor working in an FPA clinic.

B THE PRESENTATION

1 *Appearance and manner*
The doctor could not remember what the patient looked like when she came to record the interview.

2 *Complaint*

Her husband did not desire sexual intercourse as often as she did.

3 *What brought the patient then?*

The patient had become anxious, to the extent of having frequent, loose bowel actions.

C 1 FACTUAL MATERIAL RELEVANT TO THE DIAGNOSIS

She had enjoyed intercourse when they were first married, achieving orgasm sometimes, but she had enjoyed it less since the birth of her child. Her husband had become increasingly disinclined for intercourse during this time, and now seemed impotent. There had been a slight improvement after they had decided to have a second child.

Her father was an embittered man, crippled in the war, who drank heavily. He was often away on business and died before she was twenty. He liked to show her off in company, but paid scant attention to her in the home, except that once when she was eleven he got into bed with her, after he had been drinking, and made her touch his penis. He then went to sleep.

The patient had slept with her mother since the age of four, father sleeping in a separate bed, ostensibly because of his injuries. Her mother was also a bitter woman, but was a competent mother none the less. She often talked of walking out of the home, but never actually did so. She refused to go out drinking with her husband, however, and so he took his daughter, who sat in the car while he went and drank in the bar. She had elder brothers.

Her husband was the exact opposite of her father, and she decided to marry him when she thought that he was being attracted by another girl who worked in the same office. They had different social backgrounds, though she did not make much of this, saying only that his family thought hers very well off.

2 GENERAL COURSE OF THE INTERVIEW AND IMPORTANT MOMENTS

She talked freely, but without showing any strong feelings, so that there was nothing remarkable to report about the texture of the material.

D PHYSICAL EXAMINATION

Not considered appropriate at the initial stage.

E SEXUAL DEVELOPMENT AND MARRIAGE

1 *Premarital*
Notable absence of information about this. Only the incident with her father was remarkable, though she did express some contempt for men at the second interview, in response to an interpretation.

2 *Marital*
Her husband's impotence had made her feel that there was something wrong with her that made her uninviting to him sexually. On the other hand, she did not feel that she should take any initiative to try to make herself more inviting, seeing this as acting like a prostitute.

F CONCEPTION OF SELF AND OTHERS

1 *Self*
Resentful at not being satisfied sexually, but now uncertain whether she is sexually attractive.

2 *Spouse*
Thinks that he is failing in his duty towards her, and feels unnoticed by him as a person.

3 *Others*
Father had made life hell for the family and had embittered her mother.
Her child was not mentioned.
She regarded men in general, and her father-in-law in particular, as rather inferior and contemptible beings.

G DOCTOR–PATIENT RELATIONSHIP

1 *How the patient treated the doctor*
The patient became increasingly antagonistic towards the doctor as the treatment proceeded.

2 *How the doctor treated the patient*
The doctor was interested in meeting the challenge presented by this patient.

H SUMMARY (as amended in the light of the group discussion)

1 *Ways in which the disturbance is shown*
Has uncertainty and doubts about her femininity. Perhaps initially made an impression of helplessness on her husband.

2 *Presumed meaning of the above in psychodynamic terms*
Uncertain sexual identification of herself; oscillating between *love for a crude and sexually active father* and love for a bitter, resentful, indignant mother.

3a *Points in favour of focal therapy*
(ii) Fairly good ego-strength.
(iv) Recent exacerbation of disturbance.
(vi) Asks for help.
(viii) Responds to interpretations to limited extent.

3b *Points against focal therapy*
(i) Essentially a pregenital type of disturbance.
(iii) Poor relationships.
(iv) Long-standing disturbance.
(vii) Developing antagonism in interviews.
(viii) Nearly petrified character structure.

4 *Focal aim*
To liberate some of the patient's compassion for her father (experienced in the past) towards her husband (in the present). *Clear focus.*

5 *Prediction*
Guarded prognosis. It was felt that twenty sessions would be needed to achieve a satisfactory result, though the doctor thought it unlikely that the patient would be able to accept this length of treatment.

Criteria of success
The patient would be able to accept her husband as a worthwhile partner, and their sexual life would become fairly satisfactory. There should be no secondary frigidity after the birth of the second child, of whom she would be able to speak spontaneously.

I SUMMARY OF THE GROUP DISCUSSION

As in the report of her husband's case, there was a spate of information and a dearth of psychological material. The doctor-patient relationship was reported in laconic style, though this highlighted the antagonism developing in the interviews.

The patient was clearly angry that the fact that she was pregnant seemed to make her complaints against her husband lose a good deal of force. She appeared to have difficulty in tolerating a sexually potent man, and yet needed desperately to be reassured about her femininity. Altogether she seemed uncertain of her sexual

identity, and this perhaps represented the most fruitful line of approach in the treatment. Her amazement at her pregnancy really expressed doubts about herself as a woman, which she presented to her husband in the guise of helpless indignation. In the courtship, her husband might well have misinterpreted her doubts and uncertainties as helplessness, which had, in turn, attracted him.

She apparently felt guilty about her affection for her father, which persisted in spite of his sexual approach to her. If she was liberated from this guilt she might be able to accept her feminine sexual role without feeling bitter and resentful; she might even enjoy it. On the other hand, there was some danger that the guilt feelings made her afraid of her own sexual excitement in relation to her father (and so husband), and this would then militate against a successful brief psychotherapy. To attempt to include her relationships with both her parents would be a negation of the concept of a focus, and would involve a comparatively long treatment.

The focus became clear only after the second group discussion, but from the first it was apparent that the handling of the transference was crucial in that the doctor seemed to have been given the role of the competent, dominating, and chilly mother. However, the patient's character structure was not yet petrified, since she seemed capable of responding to interpretations to a limited extent.

SUMMARY OF THE COURSE OF THERAPY

The patient soon reported the resumption of sexual intercourse, but did not express enthusiasm about it. The absence of excitement, which was marked, allowed interpretations bearing on the excitement she must have experienced in company with her father. These, in turn, enabled her to express warm feelings towards him, but also her resentment when he had ignored her. This again was related to her difficulty in expressing her feelings in case they were rebuffed, and she accepted this.

The patient then appeared garishly dressed, having developed a fad for cleanliness and a heightened sense of smell. This behaviour was seen to be in the nature of a manic defence against the depression resulting from feeling that communication with her husband had become increasingly an exchange of angry feelings.

Later, she became overtly depressed, and recounted how she had had similar bouts as a child, and on one occasion had made a

suicidal gesture. At this point she told of her father's lack of sympathy for her when she was ill, and also of how he accused her of ganging up with her mother behind his back. She felt that there was some truth in his allegation.

After this episode the depression lifted and she seemed keen to achieve something positive from the marriage. She felt more and more sorry for her father and began to appreciate her husband's kindness. Intercourse was more frequent and more enjoyable. Although she hoped for further improvements, she was able to accept her husband's difficulty sympathetically.

Following the birth of her baby, she wrote a letter to the doctor, as promised. It was very stilted, but expressed the pride of her husband and herself at having a son of whom, to her surprise, she was not afraid. She mentioned an increased feeling of family unity, and thanked the doctor for her continuing interest, which she did not appear to expect.

K OUTCOME

Eight sessions in all, two before presentation on the Form.
Two group discussions, after the second and fifth interviews.
Successful result within the limits specified.

Some progress had been made towards the patient's accepting her husband as an exciting partner, with a consequent easing of the marital relationship. This improvement had allowed her to be more understanding, compassionate, and maternal. In fact, the character structure had developed a little with more identification with the feminine role, the antagonism having been worked with in the transference.

However, although she had allowed her husband to become more of a man, she had at the same time become quite depressed, and this might have destroyed the possibility of brief psychotherapy. The doctor had let the patient wander away from crude sexuality, so that everything had been conducted on a polite, conventional level. At worst, she might have withdrawn from the treatment prematurely because she could not come to terms with it. The depression might not have occurred if the doctor had dealt with her difficulty in expressing excitement in terms of trying to see her love for her father, and had then led this back into the marriage by helping her to see her husband as an acceptable man. In fact,

this sort of change had occurred after she emerged from the depression, but a grave risk had been run.

The stilted letter proclaimed a success on the surface, but her basic personality was essentially unchanged. She had clearly received as much as she wanted from the doctor, and then had dismissed her politely. Although the criteria of success were fulfilled, the underlying feeling of rigidity remained.

CHAPTER 6

Gender in the Treatment Situation

The two cases discussed in this chapter proved, in fact, not to be amenable to brief psychotherapy, but they have been selected for presentation for other important reasons.

First, they illustrate the limitations of the technique in two different ways: in the one case, because a focus was absent; in the other, because the factors militating against focal therapy were too strong. Second, they show that the outcome could be largely governed by the respective sex of doctor and patient.

In his Foreword to *Virgin wives*, Balint writes:

'The classical gynaecological examination permits the doctor to examine not only the anatomical condition of the female genital organs, but also, to a considerable extent, their physiological or pathological functioning. Our method . . . was to integrate into a single performance these two examinations with a third – a thorough psychological examination of the woman's emotions and fantasies centred on her genital organs and their functions. One reason why in our work this could be done fairly easily was that all the doctors as well as the patients were women.

At this point it should perhaps be mentioned that we are fully aware that our research work has studied one side only of the complex problem of non-consummation. Our experiences have taught us something about the woman's contribution to this impasse. This does not mean that we think the man's contribution is unimportant; only that our setting did not enable us to study it. In any case it would be difficult to create conditions for a proper psychosomatic diagnosis and therapy for the male partner's problem. We do not know of any accepted examination that would supply the doctor with reliable data about the physiological or pathological functioning of the male sexual organs, and the emotions and

fantasies of the man centred on them, in the way that a gynaecological examination does in the case of the female. In the same way, we cannot be certain what influence the sex of the examining doctor may have on the data obtained.'

The two cases that follow show that, in the setting in which a male patient is being treated by a male doctor, examination of the genital organs may give rise directly to situations which, although very revealing, may also be very difficult for the examining doctor to deal with. On the other hand, a woman doctor, when she is treating a man, may find herself at a disadvantage just because a psychological investigation of the man's fantasies and emotions centred on his genital organs is not accessible in the way that such an investigation of the woman's fantasies is possible when she is treating a woman; and this disadvantage may well allow the negative factors in the case to determine the outcome.

It must therefore be said that the present research does not solve the problem of whether there is an acceptable examination of the male genitalia that will yield reliable data of this kind, but confirms the impression that such information would be very valuable.

MR DRUMMOND

A PRELIMINARY FACTS

1 *Doctor:* Dr Rodney (Male).

2 *Patient:* Aged 24. Married three months.
Machine-tool operator.

Spouse: Aged 19.
Secretary.

Children: None.

3 *Referral:* The patient brought a long, rather confused, letter from a doctor whom his wife had approached for contraceptive advice.

B THE PRESENTATION

1 *Appearance and manner*

Tall, with unkempt hair, having the air of a man who lived by his wits. Told his story unwillingly after arriving late.

2 *Complaint*
Unable to ejaculate in sexual intercourse. Uncertain whether very worried about this on his own account.

3 *What brought the patient then?*
Came under pressure from his wife and her doctor.

C 1 FACTUAL MATERIAL RELEVANT TO THE DIAGNOSIS

He met his wife through his best friend's girl-friend. He had been very attached to this friend for some years, though no physical relationship was admitted. He had intercourse with his wife before they were married, but did not ejaculate, and this situation continued after marriage. He used to ejaculate when he masturbated, though he denied ever having nocturnal emissions. His wife was now becoming disinclined for intercourse and unsatisfied with the marriage.

His father had been much older than his mother, drank heavily, and died when the patient was eighteen. At the time, he was in hospital with rheumatic fever and he remained in hospital nearly a year. He was told that he had been very ill because the rheumatism had affected his heart. He made a good recovery, however, and returned to finish his training. He had shone at school in his early years, but did less well later because he was more interested in sport and in joining a gang of boys, and so he had had to take an engineering apprenticeship rather than go on to a technical college.

He had an elder sister, still unmarried.

2 GENERAL COURSE OF THE INTERVIEW AND IMPORTANT MOMENTS

The interview started late and went slowly, but the material was coherent. The patient showed resentment when he spoke of his mother's having spoiled him in order to buy his love. He greatly regretted not being able to attend his father's funeral.

His coming late, his inability to talk in the session and to ejaculate in intercourse, were interpreted as meaning that he found it hard to give. He passively agreed with this, rather than actively accepted it as something to work with, remarking that his wife was always saying that he could not let himself go.

D PHYSICAL EXAMINATION

He had great difficulty in passing urine in the presence of the doctor, and this was immediately interpreted in terms of not being able to let himself go. He was then able to urinate, and this was interpreted as showing what he was capable of when he was encouraged.

He responded by demonstrating his masturbation technique whereby he tried to prevent the semen escaping from his prepuce. The doctor experienced anxiety at this demonstration, but nevertheless interpreted that once again he was not able to give anything of himself away.

E SEXUAL DEVELOPMENT AND MARRIAGE

1 *Premarital*

He did not go out with girls before he met his wife, but had masturbated with heterosexual fantasies.

2 *Marital*

His expectations of marriage were vague, but, by identifying himself with his best friend's intention of getting married, he was hopeful that his own marriage would be a success.

F CONCEPTION OF SELF AND OTHERS

1 *Self*

He considered himself unhappy, unable to love because he did not know what love meant.

2 *Spouse*

He thought of his wife as better than any other girl he had met, but his feelings were again vague.

3 *Others*

He could not give his mother the affection she demanded; in fact, he had more loving feelings towards his sister. He had been affectionate towards his father, but had thought him too old for his mother.

He liked his in-laws, because they displayed affection towards him without demanding too much of him.

G DOCTOR–PATIENT RELATIONSHIP

1 *How the patient treated the doctor*

He treated the doctor with suspicion at first, but then became

rather too forthcoming, which seemed to reflect his uncertainty as to his role.

2 *How the doctor treated the patient*
The doctor treated the patient with firmness, not allowing him to retreat into his usual pattern of not giving anything without interpreting it. He became anxious when this approach resulted in the patient's demonstrating his masturbation technique during the physical examination.

H SUMMARY (as amended in the light of the group discussion)

1 *Ways in which the disturbance is shown*
Failure to ejaculate in sexual intercourse. Cannot love his wife; in fact denies feeling love or hate. Masturbates in such a way as to restrict ejaculation. Blames everything on his mother, and also has some negative feeling towards his father. Allows men to do things for him (e.g. best friend and doctor).

2 *Presumed meaning of the above in psychodynamic terms*
Homosexuality.

3a *Points in favour of focal therapy*
(vi) Needs help badly (returned after a month's wait for second session).
(vii) Communicates with the doctor in his own way.
(viii) Can understand interpretations.

3b *Points against focal therapy*
(i) Severe and generalized psychopathology.
(ii) Poor ego-strength.
(iii) Very poor relationships (except to best friend).
(iv) Lifelong disturbance.
(vi) Passive mode of referral.
(vii) Exhibitionist mode of communicating, arousing doctor's anxieties.
(viii) Too passive agreement with interpretations.

4 *Focal aim*
No focus more circumscribed than his homosexuality emerged.

5 *Prediction*
Long-term treatment required, since there was nothing that could be defined as a focus within the limits of his homosexuality. *No focus.*

I SUMMARY OF THE GROUP DISCUSSION

The group identified itself with the doctor's anxieties in the matter of the demonstration of the masturbation technique. It was viewed as a kind of seduction of the doctor on the part of the patient, almost an attack. The doctor had obviously been surprised at the change in the patient's demeanour, but had nevertheless reported it in a very cool way.

It was thought that the doctor's encouragement of the patient to pass a specimen of urine must have been interpreted by the patient as a seductive approach, to which he had responded. But, having forced him to disclose his intimate feelings, the doctor had been unable to give the patient anything in return, this perhaps being something of an echo of the attitude of his parents towards him. It seemed likely that there had been communication at cross-purposes during the interview, and that the doctor was not very sympathetic, in fact rather hurried and hostile, so that the patient had been able to break through the barrier only by an exhibitionist mode of approach. It was thought that, unless the doctor could make contact with the anxiety and guilt feelings that prompted the patient to try to show the doctor his intimate feelings, the misunderstanding would continue and the communication would cease altogether.

J SUMMARY OF THE COURSE OF THERAPY

It soon became evident that the patient's problem was an inability to feel much except in a 'homosexual' relationship. He implied feeling in what he said, but when it was discussed in detail there was no real warmth. As the interviews proceeded the patient appeared to be telling the doctor not to bother with the questions of family or marital relationships, but to concentrate on the doctor–patient relationship alone. For this reason the doctor felt unable to continue the treatment and considered that he should refer the patient, but he realized that the patient was not immediately ready for such a change.

It transpired that the patient had become aware of homosexual behaviour when he was twelve, having seen men go into lavatories together, and had himself been accosted on one occasion. He was disgusted, but also rather excited. He eventually admitted that he had fantasies of wanting to be a woman and be penetrated, and that he was anxious that masturbation had made ejaculation

impossible for him. He expressed a great deal of resentment against women in general, and his wife in particular, but eventually dried up in the sessions; at this point the doctor broached the question of referral and the patient agreed.

He was referred to an appropriate clinic, and was put on the list for group therapy, the psychiatrist agreeing that his symptoms were very much a part of his character structure, though he seemed anxious to have treatment. The doctor did not see the patient while he was waiting for a vacancy in a group.

K OUTCOME

Six sessions in all, one before presentation on the Form.
Two group discussions, after the first and third interviews.

This case was considered unsuitable for brief psychotherapy because the disturbance could all be explained in terms of the patient's homosexuality; and, since no more circumscribed focus crystallized out of the material, long-term therapy was mandatory within the terms of reference of the research project.

Referral thus became inevitable, but the doctor was criticized for his rejection of the patient as soon as the referral was made, although there was going to be some delay before he could be admitted to alternative treatment. On the other hand, the doctor felt that a deepening relationship might have created difficulties for the homosexual patient when he came to join a group, though he admitted that his own anxiety was a major factor in his decision not to continue to see the patient from time to time.

This anxiety had arisen in the context of the physical examination of a man's genital function by a male doctor, and it was this particular setting that provoked the exhibitionist response by the patient that so alarmed the doctor.

MR EAST

A PRELIMINARY FACTS

1 *Doctor:* Dr Sloane (Female).
2 *Patient:* Aged 36. First marriage (at age 21) annulled after one year. Married for second time for ten years.
Caterer.

Spouse: Aged 30.
Children: One, aged 6.

3 *Referral:* By a psychiatrist who was not prepared to take on another psychosexual case at the time.

B THE PRESENTATION

1 *Appearance and manner*
An unremarkable looking man, with an easy manner.

2 *Complaint*
Cannot ejaculate in intercourse. Bewildered by this.

3 *What brought the patient then?*
His wife had left him, taking the child with her.

C 1 FACTUAL MATERIAL RELEVANT TO THE DIAGNOSIS

He came from a home where the parents were always fighting. He had a brother and sister with whom he got on quite well, but they were never on close terms. The war split the family up, for they were evacuated, but he liked the family he lived with. He had a reputation there for picking fights. He was in the Navy for a while, and returned home afterwards to find things unchanged, so he married to escape.

His first wife brought a nullity action against him after a year, which he did not defend. He went to live as a lodger in the house of an older friend, whose daughter he married after a while. They lived in furnished rooms for a time, then moved back into her parents' house, where they had a large flat.

His wife became anxious to have a baby after some time, and he went for psychiatric treatment, but without improvement; so artificial insemination (he being the donor) was arranged, and this succeeded rapidly. He was not interested in his daughter when she was born, but had grown to love her as he had never loved anyone before. In fact, his wife seemed to have become jealous of this love, and after frequent rows had left him and was running a boarding-house with her mother, using her savings as capital. He still took the child out every weekend.

He now had a new girl-friend who was kind to him.

2 GENERAL COURSE OF THE INTERVIEW AND IMPORTANT MOMENTS

The only emotion he showed was towards his child. He showed

little anger or grief over his wife's behaviour and was at a loss to understand his own problem. He was certain that there was nothing organically wrong, but did not see what talking could do to help. Nevertheless, he wanted to come back and see the doctor.

D PHYSICAL EXAMINATION

Not considered appropriate.

E SEXUAL DEVELOPMENT AND MARRIAGE

1 *Premarital*

The patient remembered being attracted to girls at an early age, whistling after them, and bumping into them when possible. He was taught to masturbate by another boy when he was eleven, and did so regularly, with pleasure. He had known about homosexuality at sea, but was never interested. He had sexual intercourse from eighteen, but derived no pleasure from penetration, and masturbated afterwards.

2 *Marital*

His first wife was horrified when he wanted her to masturbate him after intercourse. This led to quarrelling and she left him to bring the nullity suit against him. He never loved her.

His second wife was more accommodating, but when she became eager to have a baby began accusing him of having other women. After the birth of their daughter, she became disinclined for intercourse, and he had less enjoyment because of her attitude.

His present girl-friend was sympathetic, but the intercourse pattern was unchanged. He did not love her either.

F CONCEPTION OF SELF AND OTHERS

1 *Self*

Considers himself a hardworking, easy-going man. Likes to have a home of his own, but is not otherwise ambitious.

2 *Spouse*

Thinks she is a nice girl, but too interested in money, which he ascribes to the poverty of her family when she was a girl. Thinks she may be missing him now that she has left him.

3 *Others*

His mother was very efficient, but seemed unloving. He hardly knew his father, who was away most of the time and finally left his mother. He gets on well with him now.

His daughter is the only really important person in the world to him.

G DOCTOR–PATIENT RELATIONSHIP

1 *How the patient treated the doctor*
The patient cooperated, but seemed to regard the doctor with amused curiosity.

2 *How the doctor treated the patient*
The doctor was interested in the patient, but became more and more irritated by his lack of emotion, on the one hand, and his glib acquiescence to any suggestions, on the other.

H SUMMARY (as amended in the light of the group discussion)

1 *Ways in which the disturbance is shown*
Cannot bear an orgasm in the vagina. Loses feeling, but not his erection. Cannot fight or stand up to women who are close to him. Cannot love anyone but his daughter. Cannot manage fully to occupy a house or a woman. He appears poor in spite of his good wages. Allows his money to be taken from him without a struggle.

2 *Presumed meaning of the above in psychodynamic terms*
Deep hatred of women; he is determined that they shall get nothing from him. Possible identification with mother. May have repressed homosexual tendencies, or he may fear being robbed, and so withdraws. *Apparently compelled to seduce mother-figures to play the active role for him*; for if he has to take the initiative he becomes frightened and cannot succeed.

3a *Points in favour of focal therapy*
(ii) Reasonable ego-strength.
(vi) Some motivation on account of his love for his daughter.
(vii) Keen to maintain contact with (woman) doctor.
(viii) Accepts interpretations.

3b *Points against focal therapy*
(i) Disturbance probably at pregenital level.
(iii) Poor relationships.
(iv) Lifelong disturbance.
(vi) Doubtful if motivation for change is strong enough.
(vii) Wants woman doctor to effect the cure.
(viii) Too easy acquiescence to interpretations.

4 *Focal aim*

To make him a real, suffering man, rather than an automatic response machine, in the context of treatment by a woman doctor, using his fear of his mother as the focus. *Diffuse focus.*

5 *Prediction*

Successful focal therapy possible, though prospects poor. To review after the fifth session.

Criteria of success

To be able to ejaculate in the vagina. To feel affection for his sexual partner.

I SUMMARY OF THE GROUP DISCUSSION

The patient's ambivalent attitude towards women was considered as the crux of the problem; he showed an enormous need for them, but also great hostility. No woman was likely to stand being treated as an object indefinitely, and his second wife might have left him because of jealousy of his affection for his daughter. It could even be that she hardly considered the girl to be his child in a full sense. There was the further possibility that the patient equated ejaculation with fighting, and felt that he could not fight women, so he ended by frustrating them.

He also had a great need for a home, and yet here again was shy of taking over the full responsibility. He liked to be in the position of a lodger, even if he was responsible for the upkeep of the whole house.

It was still an open question whether he could not, or dare not, have an orgasm in the vagina. He might be withholding his ejaculation for fear of being somehow robbed. If he was going to be helped he would have to become unhappy as a first step.

J SUMMARY OF THE COURSE OF THERAPY

It emerged that his masturbation fantasies had always been associated with his mother, or somebody's mother. None of his girlfriends had minded mutual masturbation, though some had wanted penetration as well. At one stage, when he was first married, he became worried about the possible harmful effects of masturbation and desisted for a time. When he had intercourse the next time he ejaculated and described this as being like masturbation, which

disgusted him, and he refused to enter his wife again; it was this that really led to the break-up of the marriage. He admitted, then, that he had an underlying hatred of women, and refrained from ejaculating to cheat them of humiliating him.

It also transpired that he married his second wife after he had been given notice to quit the house by her father, and it seemed that he had used the marriage in order to acquire a home that he had not had to build up himself, though he was quite content to finance it. He was still allowing his wife money for the keep of the child, just as previously he had given her so much money that she had been able to afford to rent her boarding-house out of what she had saved.

His relationship with his present girl-friend was running true to type, and he had already warned her that he was likely always to be somewhat odd sexually. She wanted to marry him.

The doctor felt that she was making no progress, because the patient remained his interested, acquiescing, but unchanged self. She therefore challenged him, saying that he did not seem interested in changing himself, and wanted the doctor solely to help him to get his wife and daughter back for him. He good-humouredly agreed, adding that he had given up hope in that direction, and wished only to be assured that his present partner would not turn sour on him in due course. The doctor showed that she obviously could not give such a guarantee in the light of his previous marital experience, and tried to make him angry, but without success. The treatment was terminated on a mutual basis.

K OUTCOME

Six sessions in all, one before presentation on the Form.
Two group discussions, after the first and third sessions.
Failed treatment.

The cautious prediction had been justified, the patient having succeeded in defeating the doctor by his passivity. From the start, the pattern in the interviews had paralleled the situation in his sexual relationships. The patient had been interested and cooperative without making any real effort to work with the interpretations and without expressing any real desire for change in himself. Even at the end, the situation with his new girl-friend might have been

interpreted in terms of his not being able to sustain a relationship with her without the doctor's (mother's) help, and yet the doctor's reaction had been to try to get a rise out of him.

The accident that the doctor was a woman in this case seemed to have mobilized the patient's defences to such an extent that a successful outcome would have been very difficult to achieve, and, in the event, was not possible.

CHAPTER 7

Prediction and Outcome

In the three preceding chapters the reports of six of the cases studied have been given in detail to show how a case was formulated and how the treatment was followed until an outcome was reached. The outcome was then related to the original formulation, especially to the prediction it contained, with a view to testing the accuracy of the diagnosis and discerning how various factors were more or less important in the conduct of the case. The cases were also chosen to illustrate various treatment situations commonly met with in the sort of setting described.

To have presented all the cases in this way would have produced an account of unmanageable length, and it is doubtful whether the wood could have been seen for the trees; on the other hand, a bald statement of the percentage of 'successful' treatments would have been meaningless in the absence of some concrete evidence and would have been no demonstration of the accuracy of the method of formulation. It is perhaps obvious that the [illegible] result [illegible] treatment [illegible], many things can be predicted about the patient, but the doctor is unpredictable. For instance, in two of the cases (Mrs Amherst and Mrs Derwent) proper handling of the transference situation was the key to a successful outcome, and both these treatments failed. It might, however, be argued that it is a *sine qua non* of an interpretative psychotherapy that the transference situation be properly handled. But *post hoc* rationalizations are all too easy to introduce in trying to explain the failure of a treatment.

To try to avoid the disadvantages of both the overfull and the too brief methods of presentation, the summaries of all the cases capable of formulation (and the record of one case in which such a formulation was found impossible on the evidence available) are appended

to this chapter, so that some evidence, at any rate, is available to the reader. These summaries were recorded on cards when the formulation was complete. In general, cases were deemed suitable for focal therapy if a proper formulation of the case was possible and a focus became apparent, though it was appreciated that other factors would have a profound bearing on the outcome, and these were listed on the Form as points in favour of, and points against, focal therapy. While these points were taken into consideration when the prediction was made, no clear idea of their relative influence was available, though the work of the Focal Therapy Workshop had indicated that they were indeed of consequence.

In his book, *A study of brief psychotherapy*, Malan discusses two hypotheses with regard to selecting suitable cases for brief psychotherapy: namely, a relatively 'static' one stating that the prognosis is best in mild illnesses of relatively recent onset; and a more 'dynamic' one stating that the prognosis is best in those patients who show evidence from the beginning of a willingness and ability to work in interpretative therapy. Both these hypotheses can be broken down into more than one factor.

The static hypothesis contains:

Criterion (i): 'Mild and circumscribed psychopathology' (in psycho-analytic terms, particularly 'genital level', 'three-person', or 'Oedipal' problems; rather than 'oral level', 'two-person', 'primitive', or 'deeply depressive' problems).

Criterion (ii): 'Sound basic personality', or 'high ego-strength' – usually judged by the patient's ability
(*a*) to cope with reality
(*b*) to bear frustrations and conflict.

Criterion (iii): History of satisfactory personal relationships.

Criterion (iv): 'Recent onset' or, alternatively, a 'propitious moment' – a moment in a relatively chronic illness felt to be especially favourable because of external or internal factors.

The dynamic hypothesis contains:

Criterion (v): Material that is understandable, so that a therapeutic plan can be formulated (in the terms of

reference of the research, this would mean that the case could be formulated on the Form, and that a focus would crystallize).

Criterion (vi): Motivation that either starts high or shows a rapid increase during the diagnostic period.

Criterion (vii): Signs of developing transference – though of a not too dependent or demanding kind.

Criterion (viii): Some indication that the patient is beginning to work with interpretations.

These eight factors were taken into account in the formulation of each case, and positive or negative deviations were recorded. During the progress of the research, the prediction as to the outcome of each case was assessed by the seminar on the apparent balance between the positive and negative elements. By definition, the absence of a focus ruled out focal therapy. The crystallization of a focus was thought to indicate that a successful brief psychotherapy was possible, though the chances of success were seen to be limited by the doctor's skill and the operation of such factors as those listed above. The point at issue here is whether deviations from the expected result were due to faulty deduction or whether the original formulations contained a degree of accuracy that was not appreciated at the time of formulation.

In all cases, 'success' was measured by the patient's showing signs of having achieved the predicted criteria that were part of the formulation and were related to the estimated changes in the disturbances in his life that would be expected to occur if the focal area of the psychopathology was adequately treated.

The author has set out to score, on a three-point scale, the eight factors listed above as they are seen to bear on each of the twenty-seven cases that were found to be susceptible of formulation, in the hope that a clearer and more objective approach to the results will emerge. The scores assigned to each factor in the individual cases are shown, in heavy type, in the summaries of the cases presented on pp. 80-99 below. These scores are derived directly from the case summaries that were recorded on cards by the author, while the work was in progress, in his capacity as record officer.

Numerical scoring has been used, primarily because it readily distinguishes those cases with an excellent prognosis from those with

a moderately good one. Factors in favour of focal therapy are scored as + 1, and those against as − 1. The 'null-point', where the factors balance, is represented by a numerical score of zero (0). The method of scoring is shown in *Table 1*.

TABLE 1 METHOD OF SCORING

Criterion	*Score*		
	− 1	*0*	*+ 1*
(i)	Oral level, two-person, primitive, or deeply depressive problems	Intermediate, narcissistic, or anal-sadistic problems	Genital level, three-person, or Oedipal problems
(ii)	Poor ego-strength	Reasonable ego-strength	Good ego-strength
(iii)	Poor personal relationships	Reasonable personal relationships	Good personal relationships
(iv)	Lifelong disturbance	Long-standing disturbance, but no previous overt neurosis	Recent onset or propitious moment
(v)	No focus	Diffuse focus	Clear focus
(vi)	Poor motivation	Ambivalent motivation	Good motivation
(vii)	Dependent or demanding transference situation	Reasonable contact	Quick, good contact, without dependence
(viii)	Poor insight	Reasonable insight	Good insight

The twenty-seven cases capable of formulation were divided into two groups, according to whether or not a focus could be discovered. There were five cases in which no focus emerged and these cases, by definition, were not amenable to the technique of focal therapy. Only

the remaining twenty-two cases, therefore, were taken on for treatment.

When the scoring of the factors in these cases is tabulated and the cases are placed in the order dictated by the scores, the result is as shown in *Table 2*. The two broken lines indicate the levels above and

TABLE 2 SCORES AND OUTCOME OF THE CASES WITH A FOCUS

	Static hypothesis criteria				*Dynamic hypothesis criteria*				*Total*	
Name	*(i)*	*(ii)*	*(iii)*	*(iv)*	*(v)*	*(vi)*	*(vii)*	*(viii)*	*score*	*Outcome*
Mrs Cunningham	+1	0	0	+1	+1	+1	0	+1	+5	Success
Mrs Flaxman	+1	0	0	0	+1	0	+1	0	+3	Uncertain
Mr Addiscombe	0	+1	0	−1	+1	+1	−1	+1	+2	Success
Mr Colindale	+1	0	−1	0	+1	0	+1	0	+2	Success
Mrs Amherst	0	0	0	0	+1	0	−1	+1	+1	Failure
Mr Enfield	0	+1	0	0	0	+1	0	−1	+1	Success
Mr Fitzroy	0	0	0	+1	0	0	0	0	+1	Failure
Mrs Gladstone	−1	+1	−1	−1	+1	+1	+1	0	+1	Success
Mrs Barnet	−1	0	−1	−1	+1	+1	0	+1	0	Success
Mrs Brunswick	0	−1	0	−1	+1	0	0	+1	0	Success
Mrs Colindale	0	0	−1	0	+1	+1	−1	0	0	Success
Mrs Coppermill	+1	0	−1	−1	0	+1	0	0	0	Success
Mrs Dryden	0	0	0	0	+1	0	0	−1	0	Success
Mr Arnold	0	−1	0	0	0	0	0	0	−1	Failure
Mrs Buckhurst	−1	0	0	−1	0	+1	0	0	−1	Failure
Mr Bywood	+1	−1	−1	0	+1	0	0	−1	−1	Failure
Mrs Elgar	+1	0	−1	−1	0	0	+1	−1	−1	Failure
Mr Gerrard	0	0	−1	0	+1	0	−1	−1	−2	Failure
Mrs Addiscombe	0	0	−1	−1	0	+1	−1	0	−2	Failure
Mr Clissold	0	+1	−1	−1	0	0	0	−1	−2	Uncertain
Mrs Derwent	−1	0	−1	−1	+1	0	0	0	−2	Failure
Mr East	0	0	−1	−1	0	0	0	0	−2	Failure

below which the positive or negative factors, respectively, preponderate, and the cases that fall between these two lines have scores at the null-point, where the factors are evenly balanced.

With regard to outcome, it must be remembered that 'success' means that the results of the treatment were in the direction of the end-point predicted by the seminar in the diagnostic phase, and that 'failure' means that the results of the treatment were short of this end-point.

It is immediately obvious that all but one of the cases with preponderant negative factors had unsuccessful treatments, whereas only two of the cases with preponderant positive factors failed, though the outcome of another of the cases was uncertain.

Examination of the two failures in the group with positive scores reveals that the prognosis was doubtful in each instance. In the case of Mrs Amherst the formulation clearly showed that difficulties were expected to develop in the transference, and, in the event, the doctor was unwilling to give the sort of interpretations the group considered essential for success; in addition, the doctor overestimated the patient's capacity for insight, a true assessment of which would have reduced her score by two points. In the case of Mr Fitzroy the prediction contained the warning that he might leave treatment early because of his anxieties, and the doctor proved unable to prevent this.

When the cases with scores at the null-point are considered, it may seem remarkable that there were no failures. It must be admitted, however, that only a very limited change could be expected in the case of Mrs Coppermill, and the criteria of success were extremely modest because of the short time available for treatment. In the case of Mrs Colindale, also, the amount of change aimed at was of a modest kind, and it was understood that a large area of her personality was untouched. The apparent success in the case of Mrs Brunswick was not completely understood by the group, though it appeared valid, and there were also doubts about the fact that Mrs Barnet moved house to a place near to the treating doctor. Nevertheless, the criteria of success were met in all these cases.

In the group in which negative factors preponderated, some definite indication of a bad prognosis was part of the prediction, except in the case of Mr Bywood; the focal area itself, however, provides a clue to the cause of failure with this patient. His inability to identify with his father, and the consequent turning of his aggressiveness upon himself, suggest that in the treatment situation with a male doctor he was unable to use the interpretations offered because he saw the doctor in a father-role. Since he could not change his reaction pattern he cut

himself off from help (left treatment) rather than make a good relationship with a father-figure.

In two further cases, those of Mrs Addiscombe and Mrs Buckhurst, the prediction really suggested a trial of focal therapy rather than stated any clear-cut aims. Both these cases occurred early in the series, and the sort of approach that was used at this stage was rapidly abandoned. Referral was raised as a definite possibility in both, and did, in fact, occur in the case of Mrs Buckhurst, although by the time she entered specialist treatment it had become clear that referral should have taken place earlier. This might be considered to be one case in the series which should definitely not have been offered brief treatment.

The importance of a clear focus is well illustrated by the results. Only three of the thirteen cases with a positive prognosis (non-negative scores) had a diffuse focus, and one of these treatments failed. Conversely, three of the nine cases with a negative prognosis (scores below the null-point) had a clear focus, demonstrating that, although a clear focus must be the essential factor in this technique of therapy, the other factors must be taken into consideration. It is significant that, of the five cases with a score at the null-point, four had a clear focus, the exception being the case in which the time available for treatment, and therefore the possibilities of change, were strictly limited.

The scores for the five cases in which no focus emerged are shown in *Table 3*.

Four of these cases without a focus scored at or below the null-point. The only case to score above zero, that of Mr Frobisher, showed great promise, but no focus crystallized and the patient was unwilling, at the time, to enter long-term treatment.

A survey of all twenty-seven cases that were capable of formulation shows that, when the eight selection criteria are taken into account and scored in the manner described, the higher the score the more likely a successful focal therapy. There also seems to be a critical score around the null-point, where the positive factors are approximately balanced by the negative ones.

If a clear focus is taken as the sole criterion for a favourable outcome, then success is correctly predicted (scores of + 1 on criterion (v)) in thirteen cases. Eight of these were, in fact, successfully treated – which represents a success-rate of 61 per cent.

TABLE 3 SCORES AND DISPOSAL OF THE CASES WITHOUT A FOCUS

Name	*Static hypothesis criteria* (*i*)	(*ii*)	(*iii*)	(*iv*)	*Dynamic hypothesis criteria* (*v*)	(*vi*)	(*vii*)	(*viii*)	*Total score*	*Disposal*
Mr Frobisher	+1	+1	0	0	−1	0	+1	0	+2	Rejected long-term treatment
Mrs Duncan	0	0	−1	+1	−1	+1	0	0	0	Long-term treatment
Mr Byron	−1	0	1	−1	−1	0	0	1	−5	Long-term treatment
Mr Drummond	−1	−1	−1	−1	−1	0	0	0	−5	Long-term treatment
Mrs Concord	−1	0	−1	−1	−1	+1	−1	−1	−5	Long-term treatment

Note: The case within the broken lines has a null-point score.

When the eight selection criteria are taken together, however, again a favourable outcome is predicted in thirteen cases (total scores at or above the null-point), but ten of these were successfully treated – which raises the success-rate to 77 per cent. Of the nine cases in which an unfavourable outcome is predicted (scores below the null-point), eight (or 89 per cent) failed.

It seems, then, that the diagnostic procedure was a valid means of assessing how a case would be likely to respond to focal therapy, and that predictions to this degree of accuracy can be made by relatively inexperienced doctors using the Form as the method of recording cases, in conjunction with the technique of focal therapy.

APPENDIX TO CHAPTER 7

Case Summaries

Facts	*Disturbance*	*Psychodynamics*
Mrs Addiscombe, aged 35, journalist; married 7 years to writer, aged 37; 2 children.	Feels useless to those who love her; and satisfactory only to people who do not care for her. Depression.	Ambivalent attitude to sexual experience. *Superficial shame and underlying pride.*
Mr Addiscombe, aged 37, writer; married 7 years; wife aged 35, journalist; 2 children.	Increasing fear of impending impotence. Mild depression. Slight fear of failing in his profession. Fear of being his own man, rather than woman-possessed.	*Inability to live without a protective, steadying woman. Conspicuous lack of aggressiveness.* Possibility of anal-erotic tendencies, which must be sublimated at all costs. Possibly a good deal of the feminine in his make-up. Strong, but repressed, aggressive homosexuality.
Mrs Amherst, aged 38; married 13 years to businessman, aged 40+; 2 children.	Premenstrual tension. Strained, unhappy marital relationship.	Aggressiveness cannot be freely expressed. Her marriage is largely a defence. Husband can be attacked only indirectly, disguised as effort to please. Strong conscious homosexual feelings, repressed and denied. *Tries to be a little girl who pleases mother and expects appreciation for it.*

Selection Criteria (with scores)		*Prediction*	*Outcome*
(i) Intermediate narcissism with repression	0	Good prognosis if progress is made within 10 sessions Otherwise, referral for long-term treatment will be necessary.	Patient broke off treatment after 8 sessions.
(ii) Reasonable ego-strength	0		
(iii) Poor relationships	−1		
(iv) Long-standing disturbance	−1		
(v) Diffuse focus	0		
(vi) Sought out doctor	+1		
(vii) Deep-seated difficulty in relationship with mother, and consequent potential difficulty with woman doctor	−1		
(viii) Satisfactory response to interpretations	0		
Total score	−2		
(i) Anal-erotic level	0	Will arrive at freer relationship with his wife and daughters, bossing his wife. May be more aggressive in his work. 10 to 15 sessions	Patient is more aggressive in his work, which has prospered. Bossing his wife, but still showing dependent attitude to doctor. Transference never discussed – doctor afraid she could not take it. An otherwise good result spoilt by lack of interpretation of the negative transference 5 sessions
(ii) Good ego-strength	+1		
(iii) Reasonable relationships	0		
(iv) Long-standing difficulty	−1		
(v) Clear focus	+1		
(vi) Came spontaneously and keeps coming	+1		
(vii) Danger of chronic transference with pattern, possessive mother–submissive son	−1		
(viii) Asking for and accepting interpretations	+1		
Total score	+2		
(i) Intermediate level	0	Promising case, but unless the transference relationship is properly handled the whole treatment will fall flat. Outcome will become clear after 6 sessions	Patient took control and remained unchanged Her aggression was unmasked when the transference situation was interpreted, and this provoked the patient to take control and escape 6 sessions.
(ii) Reasonable ego-strength	0		
(iii) Reasonable relationships	0		
(iv) No overt neurosis, but somatic symptoms	0		
(v) Clear focus	+1		
(vi) Ambivalent motivation	0		
(vii) Tendency to try to please strong women and be subservient to them	−1		
(viii) Good response to interpretations	+1		
Total score	+1		

Facts	*Disturbance*	*Psychodynamics*
Mr Arnold, aged 39, designer; married 15 years; wife aged 38; 3 children.	Doesn't know what sexuality means. Poses as an innocent victim of circumstance. Needs to over-compensate and prove he is a proper man, while behaving in an immature way (lost an arm as a boy). Cannot have undivided attention for one woman. He may have the same immature approach to his work.	*His physical disability is seen as an unfair trauma, leading to the need for over-compensation* (by himself and women), his disability being resented and originating the need to improve his value, which, in turn, cannot be satisfied.
Mrs Barnet, aged 36, married 14 years to businessman (older); 1 child.	Intolerably tense and irritable. Never satisfied with what she has. Resents parents and husband. Jealous of husband's relationship with his mother. Angry if if he tries to be independent. Cannot tolerate close relationships.	Feels rejected by mother and rebuffs her offers in revenge. Must have everyone fulfilling her insatiable needs. *Pays out husband for the bad relationship with her own parents.*
Mrs Brunswick, aged 25, secretary before marriage; married 7 years to clerk, aged 33; 1 child.	Frigidity, fear of losing temper. Ambivalent relationship with mother and daughter. Periodic depression, worst post-partum.	*Inability to tolerate sexual excitement in presence of anyone who might represent mother.* Introjection of the prohibiting mother with resentment and anger. Interest in mother and daughter, especially their sexual functions.

Selection Criteria (with scores)		*Prediction*	*Outcome*
(i) Intermediate level	0	Promising contact, but will probably be unsuccessful.	Patient left treatment after 4 sessions. No clear focus emerged in the second session. Doctor interpreted that the patient wanted him to produce a useful 'sexual prosthesis' just before the end.
(ii) Poor ego-strength	−1		
(iii) Reasonable relationships	0		
(iv) Recent exacerbation	0		
(v) Diffuse focus	0		
(vi) In great trouble and asks for help, *but* women have made him come	0		
(vii) Doctor may be cast in role of strong father, *but* patient may have to make a man (doctor) useless	0		
(viii) Reasonable insight	0		
Total score	−1		
(i) Severe neurosis	−1	Tension will decrease and she will allow her husband to be potent. Some help will be given towards her inability to enjoy sexual intercourse Doctor thought conflict could be resolved within 10 interviews.	Treatment terminated by mutual agreement after 5 sessions. Tension relieved Patient accepted husband's potency. Moved to house near doctor. Attitude to mother unchanged.
(ii) Fairly capable	0		
(iii) No close relationships	−1		
(iv) Lifelong disturbance	−1		
(v) Clear focus	+1		
(vi) Asked for help with good motivation	+1		
(vii) Reasonable contact	0		
(viii) Developed insight quickly, responding to interpretations	+1		
Total score	0		
(i) Severe disturbance, but circumscribed	0	There is a possibility of helping her to achieve orgasm. May need nearly 20 sessions.	Orgasm achieved in 9 sessions. Success not fully understood by seminar.
(ii) Breaks down easily when frustrated	−1		
(iii) Reasonable relationships	0		
(iv) Long-standing disturbance	−1		
(v) Clear focus	+1		
(vi) Reasonable motivation	0		
(vii) Reasonable contact	0		
(viii) Good response interpretations	+1		
Total score	0		

Facts	*Disturbance*	*Psychodynamics*
Mrs Buckhurst, aged 30; married 10 years to junior executive, aged 31; 1 child.	Depression. Despair over her femininity, defended by 'putting it on heavily'.	*Accepts femininity sexually, but tries to behave as a man in other respects.* Maintained balance by believing that she was sexy, while her husband was not. Balance disturbed when he proved himself with another woman.
[2]Mr Byron, aged 35, draughtsman; married 2 months; wife aged 22, doctor's receptionist.	Homosexuality, hetero-sexuality, and aggressiveness are problems for him. He shows general inhibition and impoverishment of feeling. He married late on the advice of a doctor, coupled with his meeting a woman who was fond of him.	The baby of the family, never trained to make efforts or decisions. Overpowering father, and idealization of women. Inability to identify himself with anyone.
Mr Bywood, aged 43, security officer; divorced first wife for adultery; just married second wife, aged 36; 1 child of first marriage.	Inability to get on in life, work, and marriages. Reduced to jelly by second wife. Inhibited aggressiveness, which is exhibited in overt, controlled way, and only when socially acceptable.	Impotence in second marriage represents overt aggression. *Inability to identify with father, so turns aggressiveness on himself, rather than into proper channels.*

Selection Criteria (with scores)	*Prediction*	*Outcome*
(i) Losing battle against depression −1 (ii) Reasonable ego-strength 0 (iii) Reasonable relationships 0 (iv) Lifelong disturbance −1 (v) Diffuse focus 0 (vi) Came for help +1 (vii) Quick transference, *but* ? too dependent 0 (viii) Reasonably receptive to interpretations 0 Total score −1	Unless brief psychotherapy produces a more stable attitude to femininity within 20 sessions, she should be referred for long-term treatment.	Patient's depression became less severe quite rapidly, but her chronic difficulties with sexuality were unchanged, and she was referred for long-term treatment after 19 sessions.
(i) Severe diffuse psychopathology −1 (ii) Good work record with some signs of independence 0 (iii) Poor relationships 1 (iv) Lifelong disturbance −1 (v) No focus −1 (vi) Fear of treatment in spite of coming 0 (vii) Fair contact with doctor 0 (viii) Capable of shallow insight only 1 Total score −5	Doubtful whether he will return for second session. If he does, his fear of treatment will be dealt with, and long-term treatment provided if possible	Patient returned, and, although he would not accept psychoanalysis, he entered long-term treatment on a weekly basis.
(i) Genital level +1 (ii) Projects difficulties on to others −1 (iii) Poor relationships −1 (iv) Long-standing difficulty (possibly ripe moment) 0 (v) Clear focus +1 (vi) Wife rebelling against maidenly role, *but* patient pushed into treatment by wife 0 (vii) Possibly good transference, *but* cannot introject good experiences 0 (viii) Poor response to interpretations −1 Total score −1	He will be able to stand up to his wife, either by consummating the marriage or by leaving her 15 to 20 sessions required.	Patient broke off treatment after 4 sessions. No reply to follow-up inquiry.

Facts	*Disturbance*	*Psychodynamics*
Mr Clissold, aged 42, business executive; married 14 years; wife aged 39, formerly overseas relief worker; no children.	Failure to consummate. Seems to have remained free of emotional ties to anyone.	*Absence of aggressiveness or any strong feelings, possibly because of fear.* Very strong ambivalent bisexual attitude, with weak and roughly equal homosexual and heterosexual propensities. Strong character defences, apparently not very strong instinctual urges.
[1]Mrs Colindale, aged 23, secretary before marriage; married 4 years to clerk, aged 31; 1 child, another expected.	Uncertainty and doubts about her femininity. Perhaps made an initial impression of helplessness on her husband.	Uncertain identification, *oscillating between love for crude and sexually aggressive father* and love for bitter, indignant, resentful mother.
[1]Mr Colindale, aged 31, clerk; married 4 years; wife aged 23, secretary before marriage; 1 child, another expected.	Preference for helpless women; runs away if they become dominating. Instead of fighting them, withdraws and becomes impotent.	*Experiences any demand by women as a threat to his masculinity*, projecting it into them and hating it resentfully.

Selection Criteria (with scores)		*Prediction*	*Outcome*
(i) Pregenital level	0	Will consummate marriage. Many of the group thought success could be achieved only by the concurrent treatment of the wife, who was, in fact, receiving treatment	Treatment petered out in an inconclusive way. After 6 interviews the focus was no more circumscribed Patient admitted aggressive feeling towards his wife, but resisted interpretations on this point.
(ii) Good ego-strength	+1		
(iii) Uninvolved in relationships	−1		
(iv) Long-standing difficulty	−1		
(v) Diffuse focus	0		
(vi) Perhaps not strongly motivated, *but* returned to doctor several times	0		
(vii) Reasonable contact	0		
(viii) Considerable resistance to interpretations	−1		
Total score	−2		
(i) Essentially pregenital	0	She will be able to accept her husband as an equal and worthwhile marriage partner, with a fairly satisfactory sexual régime, and without secondary frigidity after the birth of the baby. About 20 sessions will be necessary.	After 8 sessions there was some progress towards her accepting her husband as an exciting partner to whom she could show compassion, with easing of the marital relationship. (She did not appear to have faced the question of crude sexuality, however.)
(ii) Reasonable ego-strength	0		
(iii) Poor relationships	−1		
(iv) Recent exacerbation in long-standing disturbance	0		
(v) Clear focus	+1		
(vi) Asks for help	+1		
(vii) Growing antagonism in interviews, centred on development of transference with doctor in hated-mother role	−1		
(viii) Not yet petrified character structure; limited response to interpretations	0		
Total score	0		
(i) Genital level	+1	He will have more frequent and enjoyable intercourse, and become able to dominate his wife without arousing her resentment. 10 to 12 sessions.	Achieved more frequent and enjoyable intercourse. 9 sessions (Change in deeper disturbance was less *certain.*)
(ii) Reasonable ego-strength	0		
(iii) Helpless and demanding attitude to women, deeply ingrained	−1		
(iv) No previous breakdown	0		
(v) Clear focus	+1		
(vi) Wants to come, *but* involved in treatment by wife	0		
(vii) Good contact	+1		
(viii) Responds to interpretations	0		
Total score	+2		

Facts	*Disturbance*	*Psychodynamics*
[2]Mrs Concord, aged 25, shorthand-typist; married 4 years to restaurateur, aged 31; no children.	Inability to face any change in her unsatisfactory sexual relationship.	Faults on both sides in principle, but all the husband's fault in practice. Immense fear of world (including herself and her mother) not being beautiful.
Mrs Coppermill, aged 28; married 6 years to naval officer, aged 30; 3 children.	Physical, probably conversion symptoms.	Anger with father for not being satisfied with her as a woman. Fear of aggressiveness and sexual feelings. Yearning that mother would accept her even when she was vomiting. Diffuse focal area.
Mrs Cunningham, aged 20; married 6 months to bank clerk, aged 24.	Anxiety about having a deformed baby, with veiled accusations against husband for bad heredity. Compulsion to appear a perfect wife, obeying authority, while having resentment and somatic symptoms. Fear of losing control in case others may control her when she has lost it. Tendency to idealize. Slightly frigid?	Need to match up to happy marriage of her parents, and so prove herself an efficient wife in order to secure her mother's love. (Married to escape her mother's control, only to fall under her husband's.) Difficulty in suppressing her aggression and need to control her husband. *The deformed baby is possibly an expression of her revenge on her husband.*

Selection Criteria (with scores)		*Prediction*	*Outcome*
(i) Severe and diffuse psychopathology	−1	Patient was thought unsuitable for brief psychotherapy, because of resistance and denial.	7 sessions needed to achieve referral for psycho-analysis, which she entered.
(ii) Reasonable ego-strength	0		
(iii) Poor relationships	−1		
(iv) Lifelong difficulty	−1		
(v) No focus	−1		
(vi) Consulted various agencies for help	+1		
(vii) Attitude that she has done all she can	−1		
(viii) Resistance with 'sweet' denial	−1		
Total score	−5		
(i) Hysteric?	+1	No true prediction was possible, since only 4 to 6 interviews could be arranged before patient went overseas. The group thought that with a good transference relationship the hysterical symptoms would subside quickly.	Patient's symptoms diminished within 4 interviews. The couple felt more united rather than that dissension had been aired. Patient became passive in treatment. Doubt as to the sincerity of her expressed improvement.
(ii) Reasonable ego-strength	0		
(iii) Poor relationships	−1		
(iv) Chronic illness	−1		
(v) Diffuse focal area	0		
(vi) Seeks help	+1		
(vii) Good contact, but has to pretend her sexual life is good, and doctor unable to challenge this	0		
(viii) Responds to interpretations	0		
Total score	0		
(i) Genital level	+1	Will have less compulsion to be perfect, but be able to stand up to her husband, having understood and resolved her fear of having a deformed baby Needs 10 sessions (this estimate thought to be too short by some of the group)	Patient was able to express her resentment towards her mother, with the realization that she had identified herself as a (deformed) child who could not make her mother see her needs, and feared she would not be able to communicate with her baby. Patient became pregnant, and treatment terminated after 5 interviews. (Group felt doctor had not dealt with the possibility of being idealized.)
(ii) Reasonable ego-strength	0		
(iii) Reasonable relationships	0		
(iv) Comes for help soon after marriage	+1		
(v) Clear focus	+1		
(vi) Apparent eagerness to be understood	+1		
(vii) Good contact, but some danger that doctor may be idealized and then resented and despised	0		
(viii) Responds well to interpretations	+1		
Total score	+5		

Facts	*Disturbance*	*Psychodynamics*
Mrs Derwent, aged 38, fashion designer; married 5 years to artist (older), with whom she has been living for 11 years; no children.	Incomplete sexual maturity (disgust, pain, frigidity). Recent attempt to control husband, but not have his baby. Now wants professional independence and his baby, but relies on husband for birth control. Pleasure in fighting, despising, and denigrating men while chasing them, being unable to control them. Cannot enjoy what is given to her. Probably afraid of losing her husband, showing well-controlled panic in wanting (demanding) a baby. Resentful withdrawal from women not admitted.	Sexually undifferentiated. Not able to identify with either male or female role. Possibly retarded adolescent becoming afraid that it may be too late now. Not feeling herself a proper woman she tries to force the issue by having a baby, but at the same time is resentful towards her father for having wanted a son. Signs of oral fixation. *Pleasure from punishing men by controlling them.* Panic arising because husband is slipping out of her grasp.
[1, 2]Mr Drummond, aged 24, machine-tool operator; married 3 months; wife aged 19, secretary; no children.	Failure to ejaculate in sexual intercourse. Cannot love his wife. Denies feeling love or hate. Masturbates in such a way as to restrict ejaculation. Blames everything on his mother; also has negative feeling towards his father. Allows men to do things for him (e.g. best friend and doctor).	Homosexuality.
[1]Mrs Dryden, aged 34, PT instructor before marriage; married 4 years to dentist, aged 33; 2 children.	Resentful and critical, but has pleasure in controlling these feelings. Failure to accept feminine role, with neurotic need to involve husband in feminine duties, and anger if he resists. Denies what she is doing in her own marriage, but still anxious about parents' marriage, although denies this. General negative attitude to everything. Suppresses aggressive feelings and idealizes everything. Thinks external things will solve her difficulties.	

Selection Criteria (with scores)	*Prediction*	*Outcome*
(i) Severe psychopathology (oral) −1 (ii) Reasonable ego-strength 0 (iii) Poor relationships −1 (iv) Lifelong illness −1 (v) Clear focus +1 (vi) Wants help, intelligent, *but* wants help on own terms; rigid defences 0 (vii) Restrained cooperation in the transference 0 (viii) Responds to interpretations to some extent 0 Total score −2	The problem of control will become a major issue in the transference, and unless it is recognized, interpreted, and worked through, a good result will not be achieved (woman doctor). A good outcome will be manifested in signs of increased femininity and decreased resentment towards men Patient will become willing to accept pleasure in what is given. Will stop fighting for control, and *will be able and willing* to be in charge of contraception when necessary. Nearly 20 sessions required.	Patient withdrew after 5 sessions to have investigation of subfertility on an organic basis – which had been the point of referral to the doctor in the first place. Patient thus took control of the therapeutic situation, since the transference had not been interpreted and worked through.
(i) Severe generalized psychopathology −1 (ii) Poor ego-strength −1 (iii) Very poor relationships −1 (iv) Lifelong disturbance −1 (v) No focus −1 (vi) Needs help badly, *but* passive mode of referral 0 (vii) Communicates with doctor in his own way, *but* exhibitionist mode of communication, arousing doctor's anxieties 0 (viii) Doubtful insight 0 Total score −5	Long-term therapy will be needed, because there is nothing that can be defined as a focus within the limitations of his homosexuality. No focus more circumscribed than his homosexuality emerged.	After 6 sessions the patient was referred to a psychiatrist, who put him on a waiting list for group therapy
(i) Pregenital level 0 (ii) Reasonable ego-strength 0 (iii) Reasonable relationships 0 (iv) Recent exacerbation in lifelong disturbance 0 (v) Clear focus +1 (vi) Wants help, *but* only on own terms, need to control 0 (vii) Strong feelings are easily identifiable in spite of being covered up 0 (viii) Resistance to interpretations −1 Total score 0	She will lose her resentment about lack of orgasm by changing *her attitude to her* mother via the transference Her self-idealization will remain unaltered. 10 sessions, unless she becomes depressed, in which case she will need at least 20.	Patient lost her resentment at lack of orgasm after a period *of depression, which* was resolved by the liberation of her aggression in overt anger. Her need for idealization was diminished, and she had changed her attitude towards her parents. She might even have achieved an orgasm. 9 sessions

Facts	*Disturbance*	*Psychodynamics*
[2]Mrs Duncan, aged 30, schoolteacher; married 6 months to research worker, aged 24.	Need to marry a younger, passive husband whom she could control. Non-consummation. Inability to tolerate excitement or tender feelings. Need to control her anger most of the time. General confusion about everything.	Displacement away from vagina. Denial that anything could be wrong with her sexuality. Strong incestuous wishes towards father, possibly reciprocated, leading to guilt feelings. Hostility towards mother, leading to ambivalent identification with her.
[1]Mr East, aged 36, caterer; first marriage annulled after 1 year; married for second time for 10 years; wife aged 30; 1 child.	Cannot bear an orgasm in the vagina. Cannot fight or stand up to women who are close to him. Cannot love anyone except his daughter. Cannot fully occupy a house or a woman. Appears poor in spite of good income.	Deep hatred of women; he may fear being robbed, though he allows them to take his money without a struggle. Possible identification with mother; may have repressed homosexual tendencies. *Has to seduce mother-figure to act for him, because the initiative frightens him.* Cannot fight men.
Mrs Elgar, aged 28, housewife; married 3 years to company director, aged 40; 2 children.	Men hardly exist in reality, but are shadowy, unimportant, though exciting. The world is full of women, and only they matter, especially mother. Though excited, patient never has satisfaction in intercourse. No proper relationship, except with mother, and then only on an exciting homosexual level. Disgusted with mess.	Strong, though ambivalent, relationship with mother, with sexual pleasure in rebelling against her. Repeating mother's pattern of controlling husband, rejecting him, and making much of the children. Has pleasure in controlling excitement. Is not satisfied and then projects her anger against her father into him. Lives a continuously exciting life in order to impress mother-figures. Everything was an act, the real person did not appear.

Selection Criteria (with scores)		*Prediction*	*Outcome*
(i) *Intermediate level*	*0*	*Patient would achieve* relaxation and give up the impulse to control, and so allow consummation and relief of the depression. Since more than 20 sessions would be required, however, the case was considered unsuitable for focal therapy. (Some members of the group felt that consummation was possible quickly.)	*The patient had been* seen 30 times by the psychiatrist when the seminar finished. Her depression was lifting, but the marriage remained apparently unconsummated although, on examination by a gynaecologist, a *ruptured hymen* was found.
(ii) Reasonable ego-*strength*	0		
(iii) Poor relationships	−1		
(iv) Comes early after her marriage	+1		
(v) No focus	−1		
(vi) Asks for help	+1		
(vii) Patient produced depression and not the *sexual problem*	*0*		
(viii) Responds to interpretations	0		
Total score	0		
(i) Pregenital level	0	Success possible, *though prospects poor.* Prognosis will become clearer after 5 *sessions.*	Doctor defeated by *patient's passivity.* Patient brought his new girl-friend for doctor's approval. 6 sessions.
(ii) Reasonable ego-strength	0		
(iii) Poor elationships	−1		
(iv) Chronic illness	−1		
(v) Diffuse focus	0		
(vi) Some motivation because he loves his *daughter, but* doubtful strength of motivation	0		
(vii) Good contact, *but* wants woman (doctor) to 'do it for him'	0		
(viii) Too easy acquiescence to interpretations	0		
Total score	−2		
(i) Oedipal level	+1	*Prognosis for brief* psychotherapy is poor, since no clear focus emerged. Probably a good prognosis for *long-term treatment.* Patient's need to control and her *pleasure in being* angry with her husband *have to be* understood.	Subsequent material conformed with that obtained initially, so that the matter remained diffuse, and did not allow of being concentrated in a focal area *where work* could be done *in* a limited time. There were no reality signposts, *everything* crumbled at a touch. Patient lived in a fantasy world and was *not accessible for*
(ii) Reasonable ego-*strength*	*0*		
(iii) Only one strong relationship	−1		
(iv) Lifelong illness	−1		
(v) Diffuse focus	0		
(vi) Dubious motivation	0		
(vii) *Brought out* real problem quickly	+1		
(viii) Insight poor, rigid personality structure	−1		
Total score	−1		

Facts	*Disturbance*	*Psychodynamics*
[1]Mr Enfield, aged 50, buyer in textiles; married 16 years; wife aged 39, secretary before marriage; 3 children.	Loss of libido and appetite (particularly when at home). Unable to cope with elder boy; hurting himself rather than the boy by strict discipline. Not completely confident in his work. Has an intellectual approach to relationships, with notable absence of feeling, unless the object threatens to withdraw.	Narcissistic. Wants everybody to do things his way, otherwise he is not interested. *Depressed, with underlying aggressiveness.*
Mr Fitzroy, aged 26, company director; married 6 months; wife aged 21, never worked.	Non-consummation. Desire to remain in large homosexual group (army or political party) rather than small heterosexual group (nuclear family). Dread of committing himself to situation from which there was no escape.	*Disgust with women's bodies. Fear of castrating women.* Slight potential for love. Fear of pressure? Secret fixation to mother.
Mrs Flaxman, aged 26, schoolteacher; married 4 years to estate agent, (older); 3 children.	Confusion of female roles (mother, woman, and little daughter). Envious idealization of men rather than rivalry. Highly ambivalent relationship with mother.	Father above criticism must remain inviolate. with fear of losing this precarious idealization *Intense jealousy of mother in her sexual re with inability to identify positively with her.*

Selection Criteria (with scores)	*Prediction*	*Outcome*
(i) Intermediate narcissistic 0 (ii) Good ego-strength +1 (iii) Mixed quality of relationships 0 (iv) No previous breakdown, *but* long-standing disturbance 0 (v) Diffuse focus 0 (vi) Good motivation +1 (vii) Restrained cooperation with doctor 0 (viii) Resistant to interpretations. Rigid personality structure −1 Total score +1	The patient's libido and appetite will be restored. His son will do better at school, but only gradually. If the patient can accept psychotherapy quickly, only 12 to 15 sessions will be required. (If he cannot accept it, he will need long-term treatment.)	Libido and appetite were restored in 14 sessions, but patient was not wholly satisfied He still had trouble in expressing his aggressive feelings in an open manner, because there seemed no safe outlet. He had accepted psychotherapy quickly.
(i) Anal-erotic level 0 (ii) Reasonable ego-strength 0 (iii) Reasonable relationships 0 (iv) Comes soon after *crisis (marriage)* +1 (v) Diffuse focus 0 (vi) Desire to come, *but* driven into treatment by wife; afraid of treatment 0 (vii) Reasonable contact with doctor 0 (viii) Reasonable response to interpretations 0 Total score +1	Will consummate within 15 sessions or leave treatment early because of his anxiety.	Patient left treatment after 2 sessions, but consummated marriage just before his brother's wedding a few months later.
(i) Oedipal level +1 (ii) Reasonable ego-strength 0 (iii) Reasonable relationships 0 (iv) Recent exacerbation 0 (v) Clear focus +1 (vi) Returned to doctor after lapsing 0 (vii) Easy transference +1 (viii) Fairly good response to interpretations 0 Total score +3	Will become more independent, especially with regard to her parents, with concomitant appreciation of mother and husband. 10 to 15 interviews required Doctor apprehensive she would not stay the course, but group thought this dependent upon adequate interpretation of the transference.	Uncertain outcome. The doctor became the focus of the first two sessions, with consequent misunderstanding of the case. Doubtful whether patient would continue treatment.

Facts	*Disturbance*	*Psychodynamics*
[2]Mr Frobisher, aged 36, designer; married 11 years; wife aged 33, interior designer; 3 children.	Great difficulty in expressing any emotion. Dismay at emotional outbursts. Unable to take a masculine role with his wife, and takes over part of feminine role from her. Must do everything to please his wife so as to induce her to initiate intercourse, since he cannot do so himself.	Projects masculinity into his wife, hating it but excited by it. Idealization of Quaker father who was never emotional. Shame over mother who had an occasional emotional outburst, but possibly very attracted by it. Chose his wife on this pattern, and possibly educated her consistently for the role of the emotional, hysterical, unpredictable woman, who could be sexually demanding or rejecting when he must be the subservient unruffled Quaker father.
Mr Gerrard, aged 32, works manager; married 12 years; wife aged 32; 2 children.	Executive impotence after 11 years of marriage. Insidious onset, always present partially. Generally inhibited sexual life. Chronic anger, denied, with inability to express it. Always has to be right.	Paranoid, ambivalent attitude to mother. Somewhat ambivalent homosexual attitude to father (boss and doctor). *Problem with anger.* Defence against it is by control, denial, and disowning it. Over-compensation by jokes and projection.
Mrs Gladstone, aged 39; married 12 years to businessman, aged 39; 4 children.	Cannot achieve any pleasure in anything. Pretends everything is fine and under control, putting up façade at cost of losing zest. Inability to form close relationships with parents after absence. Sexual development inhibited. Silen rebellion.	*Inability to form proper emotional contact with mother-figure.* Strong ambivalence leading to this controlled, forced personality.

Selection Criteria (with scores)		*Prediction*	*Outcome*
(i) Oedipal level	+1	Not thought suitable for brief psychotherapy. There are several possible foci, but *nothing definite.*	There was still no focus after 3 sessions. Patient was unwilling to accept long-term *therapy at the time.*
(ii) Good ego-strength	+1		
(iii) *Doubtful* quality of relationships	0		
(iv) Marriage apparently good for 8 years, with recent deterioration	0		
(v) No focus	−1		
(vi) Comes because of *critical situation at home but* no focus; comes at wife's behest	0		
(vii) Steady development from deadness to meaningful communication with doctor	+1		
(viii) Dubious insight	0		
Total score	+2		
(i) Intermediate level	0	*He will regain potency,* with love-scenes and rows that will be resolved instead of ending in resentment *12 to 20 interviews.* Difficult case	*Patient* terminated treatment after 3 interviews, saying it was a waste of his time. This was *interpreted* in terms of what he was doing with his wife and boss, but the interpretation was not accepted.
(ii) Reasonable ego-strength	0		
(iii) *Poor* relationships	−1		
(iv) Recent exacerbation	0		
(v) Clear focus	+1		
(vi) Reasonable motivation	0		
(vii) *Strong* aggressive responses, very difficult to handle	−1		
(viii) Poor insight	−1		
Total score	−2		
(i) Oral level	−1	She will allow her husband to excite her and enjoy it by gaining ability to rebel openly against mother and yet still love her *10 to 15 sessions* required	More than 20 sessions Patient gained more feeling in intercourse, but related to herself *rather than to her* husband. Interpretation of this made her more angry, but she achieved an orgasm thereafter.
(ii) Strong personality	+1		
(iii) *Poor* relationships	−1		
(iv) Chronic disturbance	−1		
(v) Clear focus	+1		
(vi) Good motivation	+1		
(vii) Good *immediate* therapeutic contact	+1		
(viii) Whole person is uninvolved	0		
Total score	+1		

Facts	*Disturbance*	*Psychodynamics*
[3]Mrs Feltham, aged 19, machinist; married 3 months to carpenter, aged 19.	Non-consummation. Unable to confront wish for strong excitement. (Husband afraid of being hurt?)	Inability to identify satisfactorily with either parent. Guilt over some earlier excitement?

[1] Cases presented in the text. [2] Cases not accepted for treatment.
[3] Case not properly formulated.

Points for and against focal therapy	*Prediction*	*Outcome*
Not enough known about the patient to say whether she was suitable for focal therapy.	She will probably consummate within 6 interviews, with some satisfaction for both partners.	Consummation occurred after the first interview, but, since no proper follow-up was arranged, it is not known what this meant, for either the present or the future.

TABLE 4 THE POSITIVE SCORE PATTERN OF THE CRITERIA

	Criteria							
	(i)	*(ii)*	*(iii)*	*(iv)*	*(v)*	*(vi)*	*(vii)*	*(viii)*
No. of *successful* cases with positive scores	3	3	–	1	8	7	2	4
No. of *unsuccessful* cases with positive scores	2	–	–	1	4	2	1	1

examine the negative (— 1) scores of the criteria in the same way (*Table 5*). The results show that there is no marked difference between the successful and the unsuccessful cases as far as negative scoring is concerned. The absence of minus scores on criterion (v) is inevitably related to the chosen technique, because lack of a focus automatically precluded acceptance of a case for focal therapy. The fact that no patient was badly motivated tends to detract from the significance of the relation between a positive score on this criterion (vi) and a successful outcome, as indicated in *Table 4*, but study of the null-point scores throws further light on this matter.

TABLE 5 THE NEGATIVE SCORE PATTERN OF THE CRITERIA

	Criteria							
	(i)	*(ii)*	*(iii)*	*(iv)*	*(v)*	*(vi)*	*(vii)*	*(viii)*
No. of *successful* cases with negative scores	2	1	5	5	–	–	2	2
No. of *unsuccessful* cases with negative scores	2	2	6	5	–	–	3	3

It will be seen from *Table 6*, which relates null scores to outcome, that there is considerable disparity between the successful and the unsuccessful cases in respect of criteria (v) and (vi) only. This finding confirms, in the first place, that a diffuse focus carries a less good prognosis than a clear focus; in the second place it demonstrates that, though all the patients revealed at least a reasonable degree of motivation, those who were ambivalent in this regard were at a considerable disadvantage.

TABLE 6 THE NULL SCORE PATTERN OF THE CRITERIA

	Criteria							
	(*i*)	(*ii*)	(*iii*)	(*iv*)	(*v*)	(*vi*)	(*vii*)	(*viii*)
No. of *successful* cases with null scores	5	6	5	4	2	3	6	4
No. of *unsuccessful* cases with null scores	6	8	4	4	6	8	6	6

If we leave aside the question of the clarity of the focus, which was central to treatment technique, it emerges from the combined evidence of these three patterns of scoring that motivation was the single most important factor as far as the outcome of treatment was concerned. This might appear self-evident, but science does not always confirm prejudice. Next to this, good ego-strength and a good capacity for insight were the most influential. What is rather surprising, in view of the fairly high success-rate, is that a history of poor personal relationships (criterion (iii)) tends to be the rule. When this finding is considered in conjunction with the quality of the patient–doctor relationship (criterion (vii)), it appears that the latter relationship, which is assessed as average from the scoring, may be considered an improvement on the pattern of relationships usually found in the patients under study. This aspect of the treatment might, therefore, with advantage, be further developed.

cases are listed according to their scores on these two separate sets of criteria, two different orders emerge (*Table 7*).

TABLE 7 THE CASES WITH A FOCUS: OUTCOME RELATED TO SCORES ON THE STATIC AND THE DYNAMIC CRITERIA

Static hypothesis score		*Outcome*	*Dynamic hypothesis score*		*Outcome*
Mrs Cunningham	+2	Success	Mrs Barnet	+3	Success
Mr Enfield	+1	Success	Mrs Cunningham	+3	Success
Mr Fitzroy	+1	Failure	Mrs Gladstone	+3	Success
Mrs Flaxman	+1	Uncertain	Mr Addiscombe	+2	Success
			Mrs Brunswick	+2	Success
			Mr Colindale	+2	Success
Mr Addiscombe	0	Success	Mrs Flaxman	+2	Uncertain
Mrs Amherst	0	Failure	Mrs Amherst	+1	Failure
Mr Colindale	0	Success	Mrs Buckhurst	+1	Failure
Mrs Dryden	0	Success	Mrs Colindale	+1	Success
			Mrs Coppermill	+1	Success
			Mrs Derwent	+1	Failure
Mr Arnold	−1	Failure			
Mr Bywood	−1	Failure			
Mr Clissold	−1	Uncertain	Mrs Addiscombe	0	Failure
Mrs Colindale	−1	Success	Mr Arnold	0	Failure
Mrs Coppermill	−1	Success	Mr Bywood	0	Failure
Mrs Elgar	−1	Failure	Mrs Dryden	0	Success
Mr Gerrard	−1	Failure	Mr East	0	Failure
Mrs Addiscombe	−2	Failure	Mrs Elgar	0	Failure
Mrs Brunswick	−2	Success	Mr Enfield	0	Success
Mrs Buckhurst	−2	Failure	Mr Fitzroy	0	Failure
Mr East	−2	Failure			
Mrs Gladstone	−2	Success			
Mrs Barnet	−3	Success	Mr Clissold	−1	Uncertain
Mrs Derwent	−3	Failure	Mr Gerrard	−1	Failure

Note: The cases that fall between the broken lines have scores at the null-point. Outcome is assessed as success or failure in relation to the end-point of treatment predicted by the seminar.

alone, only eight cases would have been accepted for brief psy therapy. On the other hand, if the dynamic hypothesis criteria been applied alone, twenty cases would have been accepted for l therapy. The dynamic criteria would thus have allowed two and a times as many cases to be admitted for brief psychotherapy.

Examination of the cases with null-point scores shows that, of four cases that score at the null-point on the static hypothesis, t had a successful outcome, which represents a prognostic accurac 75 per cent. Of the eight cases that score at the null-point on dynamic hypothesis, only two were successful, giving a progno accuracy of 25 per cent.

When null-point and positive scores are considered to indic suitability for brief psychotherapy, then the static criteria predic favourable outcome for eight cases, five of which were successfu prognostic accuracy of 62·5 per cent); but they reject five succes On the same basis, the dynamic criteria predict that twenty cases likely to have a good outcome, of which ten were successfully trea (50 per cent accuracy); but they reject no successes. Thus the 20 p cent loss in prognostic accuracy is offset by the fact that twice as ma cases were successfully treated.

fail, giving a prognostic accuracy of 57 per cent. The dynamic criteria predict that only two cases will be likely to fail to respond to treatment, one of which did so (prognostic accuracy of 50 per cent). If the null-point cases are considered unsuitable for brief psychotherapy, the static criteria would predict an unfavourable outcome for eighteen cases, of which nine failed (50 per cent prognostic accuracy), and the dynamic criteria would predict an unfavourable outcome for ten cases, of which seven failed (70 per cent prognostic accuracy). Therefore, if the dividing line is drawn at the most favourable level for each set of criteria, the dynamic criteria show greater prognostic accuracy.

When the scores for the cases that were not thought suitable for focal therapy are split to give scores on the static selection criteria and scores on the dynamic selection criteria, the results are as shown in *Table 8*. The most significant consequence of this separation of the scores is that, if the static hypothesis had been employed alone, Mr Frobisher would have been considered likely to respond favourably to brief psychotherapy. Indeed, his null score on the dynamic hypothesis was high enough for him to have been accepted for focal therapy, and the reason why he was not taken on for treatment was that, in the absence of a focus, the group's technique could not be applied. He was offered long-term treatment, but declined.

TABLE 8 THE CASES WITHOUT A FOCUS. SCORES ON THE STATIC AND THE DYNAMIC CRITERIA

Static hypothesis score		*Dynamic hypothesis score*	
Mr Frobisher	+2	Mr Frobisher	0
Mrs Duncan	0	Mrs Duncan	0
Mr Byron	−3	Mr Drummond	−1
Mrs Concord	−3	Mrs Concord	−2
Mr Drummond	−4	Mr Byron	−2

Note: The broken lines mark off cases with null-point scores.

The splitting of the scores produces little change, then, in the order of this group of cases. It is interesting to note, however, that

the scores on the dynamic criteria remain consistently higher than the scores on the static criteria, even though a focus did not crystallize. This finding would seem to suggest that the criteria of the dynamic hypothesis are interrelated in some way that is not characteristic of the criteria of the static hypothesis. Indeed, such an inference might be expected on theoretical grounds, in that the static criteria tend to be logical premises drawn at random from eclectic psychiatric experience, whereas the dynamic criteria have been evolved empirically in the course of investigations with a large number of patients treated more or less on the same lines.

Certainly, the results of this research support Malan's conclusions.

APPENDIX TO CHAPTER 8

Statistical Analysis

This appendix has been prepared with the help of Dr David Malan who has kindly done all the mathematics for me. The statistical methods used (Kendall's tau_b and the Fisher test) are described in Chapter 8 of his book *A study of brief psychotherapy*, which is referred to frequently in the present volume.

The two cases with an uncertain outcome (Mr Clissold and Mrs Flaxman) have been omitted from the statistical analysis. This seems justified in that, apart from the uncertain outcome, which in both cases was thought to indicate probable failure, the inclusion of Mr Clissold would increase most of the correlations, whereas the inclusion of Mrs Flaxman would decrease them, so that the two tend to cancel each other out.

LIST OF CORRELATIONS

Total successes 10 } 20 patients in all, excluding Clissold and Flax-
Total failures 10 } man

Criterion	*Correlation*	*Probability or significance level (one-tailed test)*
(i) Level of problem	$\tau_b = +0{\cdot}07$	not significant
(ii) Ego-strength	$\tau_b = +0{\cdot}35$	$p = 0{\cdot}12$; not significant
(iii) Personal relationships	0 | −1	not significant (Fisher test)
success	5 | 5	
failure	4 | 6	
(iv) Recent onset	$\tau_b = 0{\cdot}00$	
Sum of static criteria:	$\tau_b = +0{\cdot}20$	$p = 0{\cdot}20$; not significant
(v) Focus	+1 | 0	$p =$ > 0·05, but probably < 0·1; not significant (Fisher test)
success	8 | 2	
failure	4 | 6	

(vi) Motivation		$+1$ | 0	significant at 5% level (Fisher test)
	success	7 | 3	
	failure	2 | 8	
(vii) Contact		$\tau_b = +0{\cdot}15$	not significant
(viii) Insight		$\tau_b = +0{\cdot}27$	not significant
Sum of dynamic criteria:		$\tau_b += 0{\cdot}58$	$p = 0{\cdot}0048$; highly significant
SUM OF ALL CRITERIA		$\tau_b = +0{\cdot}60$	$p = 0{\cdot}0026$; highly significant

The points that emerge from these correlations are as follows:

1. All the correlations except that given by criterion (iv), recent onset, are positive.
2. The static criteria (i), (iii), and (iv) give correlations close to zero, and appear to be valueless, though they may possibly increase the overall predictive efficiency slightly.
3. Criterion (ii), ego-strength, does give a fairly high value of tau_b ($+0{\cdot}35$), but the statistical value of this is rather limited because fourteen of the patients score the intermediate value 0, which is without predictive significance, since six were successes and eight were failures. The positive correlation thus largely depends on the three cases that scored $+1$ and were successes, and on the two that scored -1 and were failures.
4. Criterion (iv), recent onset, gives a correlation of exactly zero, the 3×2 table being as follows:

5. Summation of the static criteria produces a less accurate prediction than does criterion (ii) alone, though the limitations of the figures for that criterion have already been discussed.

6. Criterion (v), focus, gives a correlation nearly significant at the 5 per cent level, but not quite.

7. The only criterion that gives a significant correlation by itself is (vi), motivation. This agrees with the findings in respect of the Focal Therapy Workshop cases.

8. The sum of the dynamic criteria gives a much higher correlation than does any of the individual criteria alone.

Thus this statistical analysis agrees broadly with the more arithmetical analysis contained in the text of Chapters 7 and 8, but may present the results in a more convincing way for those who appreciate the statistical approach.

It is interesting that the statistical analysis would have 'drawn the line' between positive and negative predictions based on the dynamic criteria between scores of 0 and + 1, rather than between 0 and −1 as in the arithmetical analysis; because this would have rejected only two successes. On the other hand, with the static criteria the line would have to be drawn between −1 and −2 to avoid rejecting a greater number of successes.

CHAPTER 9

Follow-up Reports

In the long run the validity of the work described in this volume depends on whether the changes in the patients produced by a successful treatment are permanent, and it was one of the aims of the seminar that the follow-up of cases should be as thorough as possible.

A close watch was kept by the author, as record officer, on all the cases discussed during the life of the seminar, and interest was maintained after the research project finished. The follow-up reports are given below, with some discussion of the evidence they present.

Mrs Addiscombe

No direct contact was made with this patient after termination of treatment, but news was received via her husband (see below).

Mr Arnold

Some months after the last contact he wrote for another appointment, enclosing a cheque for the doctor's account, which had already been paid by his wife. The doctor returned the cheque, and offered him an appointment, but this was not kept. The patient's failure to keep the appointment may have been out of resentment that the doctor had refused *his* money, but probably indicated that his repetitive pattern of allowing women to be in charge of his affairs had been reinforced by this unfortunate accident. The only subsequent contact was with his wife, who approached the doctor eight months later, after she had had the baby, reporting that things were much the same.

Clearly, no change had occurred.

Mrs Barnet

Ten months after termination of treatment the patient appeared satisfied with the marital situation. There was more tenderness between her husband and herself, and intercourse was improved. Her daughter was going to be sent to a continental finishing school. (The group wondered whether the latter was an appropriate step, since the girl's orthodox education was being terminated early in order that she should attend the finishing school.) It was considered that the situation was promising, but that the danger period had not yet passed.

Two years and ten months after termination the situation seemed to have become stable. The patient returned for a contraceptive check visit, at which she reported that her husband was more potent sexually, that the tension had vanished from the home, and that she was now able to tolerate her daughter's rebelliousness and aggressiveness with good humour.

Mrs Brunswick

Two years and nine months after termination of treatment the doctor had a letter from this patient. She apologized for not having written earlier, but said that she had hoped, before writing, to be able to confirm the 'good news' that she was pregnant. In fact, however, she had not yet become pregnant.

An interview was arranged, at which she appeared worried about having another baby, though her husband was keen that she should do so. She seemed afraid of becoming depressed again. Both of them

abroad) he telephoned to make an appointment at a time when the doctor was on holiday. He did not subsequently get in touch, so the situation remained equivocal, but almost certainly unsatisfactory.

Mrs Colindale
There was no further direct contact with this patient after her letter to the doctor two months after termination of treatment (Chapter 5), but indirect news was obtained through her husband (see below).

Mr Colindale
Eight months after termination of treatment the doctor had an interview with the patient. The family had moved to a new house and he was full of his daughter and baby son. Intercourse was satisfactory, occurring at least once a week, and his wife did not make any further demands on him sexually.

Two years and four months after termination of treatment the doctor received a written reply to a follow-up inquiry (when an interview was offered), saying that they were 'chugging along quite well' in the marriage, and perhaps were 'learning the tricks of the trade'. They had had a second daughter in the interim, but had both been suffering from organic complaints (she, varicose veins; and he, pneumothorax). Mr Colindale commented that he was surprised that it was only just over two years since he had seen the doctor and that the whole treatment seemed very remote. The good result (with the reservations mentioned in Chapter 5) seemed to be confirmed.

Mrs Concord
The patient was referred to a psycho-analyst, who accepted her for treatment. She remained in analysis for a year, then continued treatment on a twice-weekly basis for some time longer. There did not seem to be much change, the reduction in treatment time being at her instigation.

Mrs Coppermill
Ten months after termination of treatment, which was brought about by the patient's having to follow her husband abroad, the doctor wrote a letter inquiring how she was. He received only a cheerful Christmas card in reply.

Mrs Cunningham
Thirteen months after termination of treatment the doctor received a

letter from the patient, who had just moved out into the country. The letter was cheerful, saying, 'I should like you to see the baby, who is now five months old, and we think just about the most fascinating child there is.' She also mentioned her husband's work and how they loved having a house of their own at last. 'I have found I can cope with most things, and if I can't, we can together.' The successful outcome seemed to have been amply confirmed.

Mrs Derwent

Four months after termination of treatment the patient returned to continue sub-fertility investigations on an organic level (this was, in fact, the original reason for her consulting the doctor). She was surprised that her husband was cooperating in this, and the doctor interpreted her surprise as being evidence of her inability to accept what her husband offered her, and of her always wanting something she had not. The group thought that the patient might have enjoyed making the doctor angry, and the situation remained unsatisfactory.

Sixteen months later (twenty months after termination of treatment) she again returned and reported that she had been much more angry and openly aggressive towards her husband and others. Her husband was happier, having had a lot of success in his work. She had often been unable to talk with him for days when he was elated, but had not realized that this had been connected with his successes.

proved negative, she appeared to be satisfied, in spite of the fact that she realized that the prospects of becoming pregnant were not good.

Although the formal focal therapy failed in the first instance (while under the surveillance of the seminar), the patient appeared to have benefited from the subsequent therapy. Thus though the case must be regarded as a failure as far as the research project is concerned, the later report would seem to indicate some improvement.

Mr Drummond

The patient was referred to a psychiatrist and taken on for group therapy (see Chapter 6).

Two years after referral he was said to be doing well in the group.

Mrs Dryden

No follow-up obtainable. This is a very sad omission.

Mrs Duncan

Two years after the termination of the seminar the patient was still in long-term therapy. The psychiatrist reported that after a period of feeling that her marriage was dead she had discovered that her husband was different from what she had believed him to be – that instead of being helpless he was quite effective about the house. She wanted to come out on social occasions and had been surprised to find him quite forthcoming in company. He even shouted back at her when she nagged. At that stage the husband asked for and accepted treatment, though his therapist reported that he was a difficult case. The marriage had been consummated and, although intercourse was infrequent, Mrs Duncan reported that her husband had ejaculated into her, and she was talking a lot about wanting a baby more than anything in the world.

She had clearly changed a good deal, and was working towards termination of treatment.

Mr East

No further contact after termination of treatment.

Mrs Elgar

The patient continued to come for follow-up checks on her contraceptive method, and had come late to the last appointment. She said that she was much better, and much less tense about everything. It was difficult to assess her condition, however, and it seemed that she

did not want to communicate with the doctor. There did not appear to be any very substantial improvement.

Mr Enfield

Twenty months after termination of treatment the doctor received a letter from the patient in reply to an offer of an interview. He apologized for not having written to the doctor on his own initiative, but said that he was 'a lot better' and that all went well with his family. 'Should this improvement not be maintained, I would be sure to let you know.' The gains in this case seem to have been confirmed.

Mr Fitzroy

Four months after termination of treatment the patient's wife's doctor reported that the marriage had been consummated (shortly before the marriage of the patient's younger brother).

Two years and three months after termination of treatment the doctor received a letter from the patient in reply to a follow-up inquiry. He wrote that they had a daughter and that his wife was expecting another baby. As far as their ordinary sex life was concerned, 'It seems to meet my wife's hopes and desires and I think we can live a very happy life. I can't pretend that I have overcome all my problems, I have just bent them to produce an arrangement that works. I suppose I should come and see you again.' It seems that the prediction was true in its assessment of both his degree of anxiety and his capacity to consummate the marriage. The case remains a failure in terms of the research, however.

Mrs Gladstone

The treatment of this case was not terminated when the seminar disbanded, and in fact proceeded for a further twelve sessions (twenty-six in all). After the twenty-sixth session the patient reported having achieved an orgasm, and it was on the basis of this report that the case was considered by the doctor and the author to have had a successful outcome.

Seventeen months after termination of treatment the doctor had seen the patient again, and she was found to be very resentful and unhappy – expecting more of her husband and the doctor than they had to give. The doctor had a Christmas card from her some six months later; on it she wrote that her husband was back in analysis, but sounded as though she was pleased with herself!

Looking back on this case one sees that it was unsatisfactory in several ways. Only half the treatment was conducted under the surveillance of the group; it continued for more than twenty sessions; and the evidence for a successful outcome seems to have been only a single orgasm. The case must be considered an unstable success, if not an outright failure.

Of the twenty-seven cases in which follow-up was attempted there was no news of six. Of these six, only one had been considered to have a successful outcome – that of Mrs Dryden. The lack of later information on this case is particularly frustrating, when one remembers that it was the opinion of the group (Chapter 4) that her attitude to her parents had undergone definite change in the face of rather daunting factors militating against focal therapy. Moreover, when the outcome was discussed, the group had made a further prediction that the achievement of orgasm might be possible for this patient.

Four more cases had very scanty follow-up reports, but, again, only one was judged to have had a successful outcome – that of Mrs Coppermill. In this case it was realized from the outset that only a limited change could be expected in the time available (four interviews), and, in addition, the focus was diffuse. No very substantial issue rested on the outcome of the treatment.

The assessment of the outcome was altered by the follow-up reports in two cases only, both of which had a clear focus: Mrs Derwent was reassessed from failure to success, and Mrs Gladstone from success to failure.

Mrs Derwent had returned to the doctor after a lapse of more than a year, and appeared to have gained some insight into her pattern of behaviour. She was not, however, a successful treatment within the terms of reference of the research.

Mrs Gladstone was still in treatment when the group ceased to meet, so that outcome was not discussed by the seminar as a whole. In fact, treatment continued for twenty-six sessions, after which the patient achieved orgasm. The author considered that this was a successful outcome in spite of the fact that the treating doctor qualified the success by stating that the patient's feeling in intercourse appeared to be related more to herself than to her husband. The follow-up report some seventeen months later shows that the doctor's doubts were justified, and the case must be classed as a failure in the long run, although the criterion of success appeared to have been met at one stage. The static hypothesis factors would seem to have had greater relevance in this case.

Thus four (rather than three) of the thirteen patients for whom a successful outcome to focal therapy was predicted must be regarded as having failed in treatment – which reduces the success-rate from 77 to 69 per cent.

Of the five patients for whom long-term treatment was considered appropriate, since no focus emerged in their cases, four had entered such treatment. Three seemed to have made some progress on the evidence of the follow-up reports; there was little information concerning the fourth patient who had accepted long-term therapy. The silence of Mr Frobisher, the fifth patient in this group, only deepens the lack of understanding as to what technique of therapy would be the most helpful in his case. The follow-up material appears to confirm that brief psychotherapy would have been very unlikely to succeed with these patients.

CHAPTER 10

Summary and Conclusions

The main object of this research-cum-training seminar was to discover whether doctors who were not psychiatrists might be trained to undertake, in a consultative setting, under the aegis of a consultant, brief psychotherapy for patients with psychosexual difficulties.

Two groups met once a week under the leadership of Dr Michael Balint and the members reported their cases in a much more disciplined manner than they had been accustomed to while working in comparable seminars oriented towards either general practice or family planning clinics. This greater discipline was necessary because the participating doctors, being mostly general practitioners, were inexperienced as regards the consultative setting inherent in this type of work, and so the treatment technique required stricter control.

By using a Form – introduced by Michael and Enid Balint in the Family Discussion Bureau, developed in the Focal Therapy Workshop, and further modified to suit the particular needs of the seminar – the group was trained to work on the raw material of the interview and to produce a report in which the case was conceptualized.

The Form set out various aspects of the case under separate headings: the first half covered the referral procedure that brought the case to the doctor, the way the patient presented, and the factual material relevant to the disturbance, together with some brief notes on the chronology and principal features of the interviews; the second half dealt with the patient's attitudes to sexuality and to other people who were important in his life, and gave some account of the doctor-patient relationship.

A summary of this recorded material was then worked out by the treating doctor and the group, with a view to understanding the disturbances in the patient's life and the psychodynamics that lay behind them. Subsequently, the various factors for and against focal therapy were assessed and, provided that a focus emerged, the aims of

treatment were delineated. Criteria of success were established in the light of the known disturbances, and a definite prediction was made as to the outcome.

A diagnosis became possible in the majority of cases at this stage, early enough for the possibilities and limitations of brief psychotherapy, as well as the most appropriate technique, to be discerned. Frequent reporting of the cases under treatment was *de rigueur*, and in this way any gross lack of skill could be discovered and corrected. By the same means, patients who were seen to have a severe disturbance might be referred without delay.

This method of reporting proved, for about half the members of the seminar, either to be too austere or to interfere with their concept of an unstructured interview. One group, therefore, abandoned the procedure, and it is the work of the other group that is reported here.

Selected cases have been presented in full, with an account of the group processes in condensed form, to show how the diagnosis was hammered out by free exchange between the treating doctor and the rest of the group. The progress of each case was followed in some detail by the group, until the final outcome was reached. At this point the success or failure of the case was evaluated, taking account of the predicted criteria of success and of the time taken to complete the

A further five cases were formulated, but, since no focus crystallized, the patients were offered long-term treatment. One declined, but the remaining four were placed in such treatment. These cases were followed up in the same way as those accepted for focal therapy, and three of the four had made progress between the referral and the time of the follow-up.

In the remaining seven cases the contact between the doctor and the patient was not productive enough to permit as complete a formulation as was needed if an early diagnosis was to be agreed. Within the terms of reference of the research project, unless such a diagnosis could be reached within three or four interviews the case was deemed unsuitable for focal therapy. For the sake of completeness, the unfinished summary of one such case is appended to the summaries of the other twenty-seven cases, to illustrate a defective formulation.

Although the technique of therapy involved the crystallization of a focus, it was realized from the beginning that the clarity or otherwise of this focus was an insufficient prognostic index in itself; therefore additional factors were taken into account when the summary of each formulation was prepared. A prediction was then attempted that would reflect the balance between the positive and negative factors in the case, in order that some idea of the possibilities of success, and of the time required to achieve it, might emerge.

The factors that were taken into account derived from the experience of the Focal Therapy Workshop, though it was decided to include not only the dynamic selection criteria, whose importance has been stressed, but also the static criteria, which had been traditionally accepted. The latter embodied the concept that brief psychotherapy was appropriate only in cases where there was a mild disturbance of recent onset, this type of illness presumably occurring in good personalities with a capacity to make good relationships. The FTW had shown, however, that quite severe and long-standing disturbances might be improved, apparently permanently, provided that the patient was well motivated, quickly established a good (not too dependent or demanding) relationship with the therapist, and had at least some ability to work with interpretations. The FTW had specified, furthermore, that a case should be able to be understood during the course of comparatively few sessions, so that an appropriate therapeutic technique could be selected. In terms of the present research, this

meant that a case should be able to be formulated in accordance with the Form, and that a focus would emerge.

When each of these eight criteria was scored on a three-point scale giving a positive, negative, or intermediate value, a total score could be assigned to the case. This score might be either at the null-point, where the positive and negative factors appeared evenly balanced, or above or below it.

In the thirteen cases at or above the null-point, there was an initial success-rate of 77 per cent, falling to 69 per cent at the end of the follow-up period. Of the nine cases with scores below the null-point, 89 per cent were seen to have failed initially, rising to 100 per cent at the end of the follow-up period.

The success-rate seems to suggest that the interests of the patients who had a relatively good prognosis were adequately safeguarded in the consultative setting. Of the patients with a poor prognosis: one was referred for long-term treatment; two remained in contact with the doctor, although the treatment failed; two decided to terminate treatment by mutual consent with the doctor; and four broke off treatment. Of these four cases, follow-up was possible in two to an extent which indicated that, although the patients had remained unchanged, the situation had not deteriorated. This leaves two cases (those of Mr Bywood and Mr Gerard) in which the treatment failed and no follow-up was possible. These two cases, and the case that was referred, were perhaps beyond the limits of safety of the method.

null-point. Similarly, the focus was diffuse in three cases with a score at or above the null-point, and in six with a score below it. Since the technique of treatment employed by the group was itself a factor leading to the selection of suitable cases, these figures may not appear especially remarkable; they do show, however, that the sharper the focus, the better the prognosis. More significant, perhaps, is that seven of the cases at or above the null-point score had maximum points for motivation, compared with only two of the cases below this score. The scores on the criteria relating to the patient–doctor contact and to the patient's capacity for insight may be examined in the same way. No case below the null-point had a maximum score for insight, in contrast to five at or above the null-point; and only one case below the null-point had a maximum score for patient–doctor contact, in contrast to three at or above it.

For the future, while the sharpness of the focus, the degree of motivation, and the capacity for insight may depend largely on the patient, it would seem that techniques leading to an increase in the doctor's skill in establishing a good patient–doctor relationship early in the treatment might be the means for improving the results of brief psychotherapy still further.

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